

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

18430

Registration District No.

Primary Registration District No.

Registrar's No.

450

1. PLACE OF DEATH:

(a) County GREENE
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1101 Pythian
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____
 years, months or days

3. (a) PRINT FULL NAME Charley Coffey
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 100

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Elizabeth Coffey 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 16 1894
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 ✓ 45 7 1 hr. min.

9. Birthplace Unknown Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Blind person

11. Industry or business _____

MOTHER FATHER
 { 12. Name Unknown
 { 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Unknown
 { 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Coffey
 (b) Address Springfield, Mo.
 17. (a) Burial (b) Date thereof May 20 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Hazelwood

18. (a) Signature of funeral director H. H. Lohmeyer
 (b) Address Springfield, Mo.
 19. (a) May 20, 1940 (b) W. C. Handley
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City, or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1101 Pythian
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
 year 1940 hour 1 minute 30 p: M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him ~~her~~ alive on May 17, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death: Stychnine Poisoning Duration 1 hour

Due to: Self (Suicide)

Due to: _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide
 (b) Date of occurrence May 17 1940
 (c) Where did injury occur? Springfield Greene Mo.
 (City or town) (County) (State)
 (d) Did injury occur in or about home, or farm, in industrial place, in public place?
Home
 While at work? No (Specify type of place) (e) Means of injury _____

23. Signature H. H. White (M. D. or other) 5
 Address Courser Greene County Date signed 5/20/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

James Osburn

Registered Apprentice No. 227

working under my personal supervision.

Signed

Leslie Gorman

Licensed Embalmer No.

3177

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18430

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

1. PLACE OF DEATH:

(a) County: Greene
(b) City or town: St. Joe
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: _____
(Specify whether
In this community: _____
years, months or days)

3. (a) PRINT FULL NAME

Charley Coffey

3. (b) If veteran, name war: _____ 3. (c) Social Security No. _____

4. Sex: m 5. Color or race: w 6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife: Stacy Coffey 6. (c) Age of husband, or wife, if alive: _____ year

7. Birth date of deceased: _____ (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 7 1 _____ hr. _____ min.

9. Birthplace: _____ (City, town or county) (State or foreign country)

10. Usual occupation: Blind Reporter

11. Industry or business: at home

MOTHER FATHER { 12. Name _____
13. Birthplace: _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace: _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof: _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation: _____

18. (a) Signature of funeral director: W. E. Handley

(b) Address: _____

19. (a) 7-6-40 (b) W. E. Handley (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations: _____

Of autopsy: _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence: _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature: R. Neal (M. D. or other) _____
Address: St. Joe Date signed: _____

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

