

Registration District No. 5-711

Primary Registration District No. 5940 4426

Registrar's No. 85

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Dixon
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski
(c) City or town Dixon
(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.

3. (a) PRINT FULL NAME Sarah Malinda Coffey 1570

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife James S. Coffey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3/10/1873
(Month) (Day) (Year)

8. AGE: Years 67 Months 1 Days 24 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name A. J. Copeland

13. Birthplace Vienna, Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lottie Holman

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

16. (a) Informant's own signature James S. Coffey

(b) Address Dixon, Mo.

17. (a) Dixon (b) Date thereof 5/5/1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixon Cemetery

18. (a) Signature of funeral director Fred H. Gilbert

(b) Address Dixon, Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 4 The year 1940 hour 7 minute _____ A. M. _____

21. I hereby certify that I attended the deceased from 10-4-39 to 5-4-40, 19____; that I last saw her alive on 5-3-40, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 3 da

Due to _____

Due to _____

Other conditions Hypertension
(Include pregnancy within 7 months of death)

Major findings: Fibrinoid of arterioles
Of operations _____
Of autopsy _____

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? 1-29

(e) Means of injury _____ (Specify type of place)

23. Signature C. Miller M.D. (M. D. or other) _____

Address Dixon Mo Date signed 5-8-40

WHILE FURNISHING THIS SERVICE, PLEASE USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

1 X1351

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.....

April 4, 1940

Registered Apprentice No.....

working under my personal supervision.

RECEIVED
District Health Officer No. 5,

District File Number. 640 646

Date Filed 6/6/40

Signed

Fred D. Gillman

Licensed Embalmer No. 2341

P. O. Address Dixon, 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. 19286

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 711

Primary Registration District No. 4426

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Pulaski
(b) City or town Dixon
(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) (Specify whether

3. (a) PRINT FULL NAME Sarah Malinda Coffey

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

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

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

8. AGE: Years 67 Months 1 Days 24 If less than one year, hr. min.

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

10. Usual occupation

11. Industry or business

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)

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 5/5/40 (b) A. S. Lick
(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.

DECEASED CERTIFICATION

20. DATE OF DEATH: Month May day 4 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;

that I last saw him 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 _____

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 C. M. Miller (M. D. or other) _____

Address Dixon Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-19286