

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

31863  
Do not use this space

1. PLACE OF DEATH  
 (a) County Dallas Registration District No. 241  
 (b) Township N. Benton Primary Registration District No. 5334  
 (c) ~~City~~ Buffalo (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Jacob C. Coffelt  
 (a) Residence, No. Dallas Co. Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha E. Coffelt

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-30-1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>78</u>	<u>7</u>	<u>26</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

FATHER 13. NAME Henry Coffelt

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Anna Lemons

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Mattha Coffelt  
Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Lawn DATE 9-27-1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) L.B. Jones  
Buffalo Mo.

20. FILED 10/10 1940 Hannay Morrow  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-26-1940

22. I HEREBY CERTIFY, that I attended deceased from Sept 9 1940 to Sept 26 1940  
 I last saw him alive on Sept 22 1940. Death is said to have occurred on the date stated above, at 9 a. m.  
 The principal cause of death and related causes of importance were as follows:  
CA of Prostate

Date of onset (?)

Other contributory causes of importance:  
Secondary

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Chemical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_ (Signed) R. E. Karnell M. D.  
 (Address) Buffalo, Mo

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.

RECEIVED

District Health Officer No. 7,

District File Number 10-40-1480

Date filed 10-11-40

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Bryce Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo 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.