

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 784Primary Registration District No. 200Registrar's No. 437

## 1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town Normandy  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
St. Vincents Sanitarium 9  
 (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 Mr. Patrick Edward Coffey  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
 6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased March 10 1887  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
53 11 14 hr. min.

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

10. Usual occupation Overseer of Farm Lands

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 { 12. Name Dennis Coffey  
 { 13. Birthplace Ireland  
 (City, town, or county) (State or foreign country)  
 { 14. Maiden name Catherine Giblin  
 { 15. Birthplace Ohio  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Rev. M. A. Coffey  
 (b) Address Gibson, Ill.

17. (a) Removal (b) Date thereof 2/25/41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Champaign, Ill.

18. (a) Signature of funeral director Albert H. Hoppe  
 (b) Address 4700 Washington Ave.

19. (a) FEB 24 1941 (b) D. R. Meyer M.D.  
 (Date received local health officer) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 96  
 (c) City or town Champaign  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 504 So. Lynn St.  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 24  
 year 1941 hour 6 minute 15 AM.

21. I hereby certify that I attended the deceased from January 30th  
 \_\_\_\_\_, 19\_\_\_\_, to February 24, 19\_\_\_\_;  
 that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
(lobar) Duration 2 weeks

Due to Influenza 1 month

Due to \_\_\_\_\_ 2 months

Other conditions Psychosis  
 (Include pregnancy within months of death) 2 months

Major findings: \_\_\_\_\_  
 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?  
 \_\_\_\_\_

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

23. Signature W. B. Juttner (M. D. or other) \_\_\_\_\_  
 Address St. Vincents Sanitarium Date signed \_\_\_\_\_

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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.....

*Albert G. Hopper*

Licensed Embalmer No.....

2971

P. O. Address.....

**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.