

Registration District No. **318**

Primary Registration District No. **2001**

**469**

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: **Burge Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **2 Hours**  
In this community **37 years**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Carrie Coffey**

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

4. Sex **F** 5. Color or race **w.**  
6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **M. J. Coffey**  
6. (c) Age of husband or wife if alive **71** years  
7. Birth date of deceased **Sept 7 1976**  
(Month) (Day) (Year)

8. AGE: Years **64** Months **9** Days **0**  
If less than one day hr. min.

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

10. Usual occupation **House wife**

11. Industry or business

MOTHER FATHER { 12. Name **John Benson**  
13. Birthplace **Unknown** (City, town, or county) **Sweden** (State or foreign country)  
14. Maiden name **Guineilla Olson**  
15. Birthplace **Unknown** (City, town, or county) **Sweden** (State or foreign country)

16. (a) Informant **Mrs. J. L. Steaton**

(b) Address **1316 N. Mason City**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **June 11 41** (Month) (Day) (Year)

(c) Place: burial or cremation **Green Lane**

18. (a) Signature of funeral director **Dean Funeral Home**

(b) Address **679 W. Walnut City**

19. (a) **6-11-41** (Date received local registrar) (b) **W. E. Handley M.D.** (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. **1303**  
(If rural, give location)  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **7**  
year **1941** hour **8** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **6-2-41** to **6-7-41**  
that I last saw her alive on **6-7-41**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to **Arteriosclerosis**

Due to **Acute Phlebitis**

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 **Henry J. Smith** M. D. or other

Address **450 1/2 S. Hamilton** Date signed

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

**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.....

*Hayd W. Ford*

Licensed Embalmer No. *2910*

P. O. Address *629 W Walnut*

**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, fact should be so stated above.**