

FILED MAR 3 1942

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

7940  
Do not use this space.

1. PLACE OF DEATH

(a) County St. Louis Registration District No. 781  
(b) Township \_\_\_\_\_ Primary Registration District No. 446.7 Registered No. 195  
(c) City St. Marys (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 Theresa Coffman

(a) Residence, No. St. Marys, Mo (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female  
4. COLOR OR RACE Col  
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min. 4  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
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) St. Marys, Mo

FATHER 13. NAME Red. G. Coffman

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Marys, Mo

MOTHER 15. MAIDEN NAME Rose Dickerson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Marys, Mo

17. INFORMANT (ADDRESS) Red. G. Coffman

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE Jan 18 1942

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Reed, B. Baker  
St. Marys, Mo

20. FILED 1/18/ 1942 John J. Thammie  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18 1942  
22. I HEREBY CERTIFY That I attended deceased from Jan 14 1942 to Jan 18 1942  
I last saw her alive on Jan 17 1942 Death is said to have occurred on the date stated above, at 6:30 a.m.  
The principal cause of death and related causes of importance were as follows:

Intestinal toxemia Date of onset 1/15/42  
Other contributory causes of importance: \_\_\_\_\_  
1942

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ 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) J. G. Wilkens M. D.  
(Address) St. Marys, 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. 4  
District File Number 242-276  
Date Filed 2-18-42

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 Lea C. Basler  
Licensed Embalmer No. 1915  
P. O. Address Dr. Genesee, Ind.

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.

Registration District No. **281**

Primary Registration District No. **4467**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH**  
 (a) County St. Genevieve  
 (b) City or town St. Marys  
(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)

**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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Theresa Coffman  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month Jan day \_\_\_\_\_  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
**21. I hereby certify that I attended the deceased from** \_\_\_\_\_  
 to \_\_\_\_\_, 19\_\_\_\_;  
 that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced D  
 6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 Birth date of deceased Jan 14 1942  
(Month) (Day) (Year)

**8. AGE:** Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ min.

**9. Birthplace:** \_\_\_\_\_  
(City, town, or county) (State or foreign country)

**10. Usual occupation** \_\_\_\_\_

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

**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** \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** \_\_\_\_\_

**18. (a) Signature of funeral director** \_\_\_\_\_

**(b) Address** \_\_\_\_\_

**19. (a)** Apr. 9/42 **(b)** T.W Douglas  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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)

**(b) Did injury occur in or about home, on farm, in industrial place, in public place?** \_\_\_\_\_

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

**23. Signature** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

**Address** \_\_\_\_\_ **Date signed** \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

S-7940