

S. No. 2
1-9-4-41
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

28595

State File No. _____

Registrar's No. 65

FILED SEP 9 1943
Registration District No. 3035

Primary Registration District No. 3035

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Lexington
(c) Name of hospital or institution: E. Main St. 1
(d) Length of stay: In hospital or institution _____
In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Lexington
(d) Street No. E. Main St.
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME ELIZABETH COEN

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 14 1868

8. AGE: Years 15 Months 0 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER { 12. Name J. P. Coen
13. Birthplace Germany
14. Maiden name Madeline Clapp
15. Birthplace Germany

16. (a) Informant Mrs. Ollie Maden (b) Address Lexington MO

17. (a) Burial (b) Date thereof Aug 31 1943 (c) Place: burial or cremation Lexington, MO

18. (a) Signature of funeral director W. W. Smith (b) Address Lexington MO

19. (a) Sept - 3 - 43 (b) Mrs. J. Schwalb (c) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1943 hour 2 minute 30 A.M.
21. I hereby certify that I attended the deceased from July 2 1943 to Aug 29 1943
that I last saw him alive on Aug 29 1943
and that death occurred on the date and hour stated above.
Immediate cause of death: General exhaustion Duration _____

Due to: Carcinoma Liver

Due to: _____

Other conditions: 46 f (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? _____
(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: [Signature] (M. D. _____)
Address: Lexington MO Date signed: 9/3/43

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

7
3
2

54
3
2

115

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

9-8-43

DEC 2 2 1943

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

Garrett J. Stump

Licensed Embalmer No.

3275

P. O. Address

Lyngton, Va

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.