

No. 2
-12-45
-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 2 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41611
State File No. _____
Registrar's No. 5307

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 hrs 40 min
(Specify whether
In this community yes 5 hrs 40 min
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 6201 E 15th Terrace 8
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Unnamed boy Coffman

3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex male 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 12 6 47
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 hr. 40 min.

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

10. Usual occupation infant

11. Industry or business _____

12. Name Virgil Lewis Coffman

13. Birthplace Laredo Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Neoma Byrdie Coffman SMITH

15. Birthplace Almena Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Neoma Byrdie Coffman
(b) Address 6201 E 15th Terrace

17. (a) RETAINED (b) Date thereof 12-7-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Trinity Lutheran Hosp

18. (a) Signature of funeral director Trinity Lutheran Hosp

(b) Address A. C. MO

19. (a) 12-17-47 (b) Beraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 7
year 47 hour 1 minute 35 A. M.

21. I hereby certify that I attended the deceased from 7:55 pm 12/6, 1947, to 1:35 am 12/7 47, 1947
that I last saw him alive on 1:35 am 12/7, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death atelectasis Duration 12-6-47

Due to prematurity 12-6-47

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 159

Of autopsy _____

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? _____

(e) While at work? _____ (Specify type of place)
(c) Means of injury _____

23. Signature Charles Harker (M. D. or other) MD

Address 1103 Grand Date signed 12/17/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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.....

Licensed Embalmer No.....

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, fact should be so stated above.