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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 15 1948
Registration District No. 99

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4171

State File No. 15864

Registrar's No. 30

32 10 0

1. PLACE OF DEATH:
(a) County De Kalb
(b) City or town Clarksdale
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community 60 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County De Kalb 32
(c) City or town Clarksdale Mo 0
(If outside city or town limits, write "RURAL")
(d) Street No. ____ 0
(If rural, give location) 3
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Robert Lee Coffey
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Molley Coffey
6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased Sept. (Month) 20 (Day) 1865 (Year)

8. AGE: Years 82 | Months 4 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Kentuckey (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business ____

FATHER
12. Name Harrey Coffey
13. Birthplace Kent, (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Kent, (City, town, or county) (State or foreign country)

16. (a) Informant Molley Coffey
(b) Address Clarksdale Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-17-48 (Month) (Day) (Year)
(c) Place: burial or cremation Clarksdale Mo
18. (a) Signature of funeral director John Bloom
(b) Address Maysville Mo
19. (a) 5-8-48 (Date received local registrar) (b) A Davidson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 14
year 1948 hour 2 minute 00 P. M.
21. I hereby certify that I attended the deceased from April 6 1948 to April 14 1948; that I last saw him alive on April 13 1948; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 days
Due to: Hypertension	
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Dr. O. R. Lawder (M. D. or other)
Address 823 Faraon St Joseph Mo signed 4-26-48

(Licensed Embalmer's Statement on Reverse Side)

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 John D Brown

Licensed Embalmer No. 3933

P. O. Address Clarksdale Mo.

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.