

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31675**

FILED OCT 2 1948

Registration District No. **217**

Primary Registration District No. **4468**

Registrar's No. **55**

1. PLACE OF DEATH:

(a) County **STE. GENEVIEVE**
(b) City or town **ST. MARY'S**
(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 **LIFE**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **STE. GENEVIEVE**
(c) City or town **ST. MARY'S**
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME **ALETHA COFFMAN**

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

4. Sex **FEMALE** 5. Color or race **COLORED** 6. (a) Single, widowed, married, divorced **MARRIED**

6. (b) Name of husband or wife **HENRY COFFMAN** 6. (c) Age of husband or wife if alive **33** years

7. Birth date of deceased **MAY 29 1915**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
33 3 14 hr. min.

9. Birthplace **ST. MARY'S MO**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business

12. Name **JOHN DICKERSON**

13. Birthplace **STE. GENEVIEVE CO. MO**
(City, town, or county) (State or foreign country)

14. Maiden name **JOSEPHINE NELSON**

15. Birthplace **STE. GENEVIEVE CO. MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Henny Coffman**

(b) Address **St. Mary's**

17. (a) **BURIAL** (b) Date thereof **9-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. MARY'S**

18. (a) Signature of funeral director **Geo. C. Bailey**

(b) Address **St. Genevieve Mo**

19. (a) **9-18-48** (b) **Teresa M. Karley**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **13** year **1948** hour **12** minute **P.** M.

21. I hereby certify that I attended the deceased from **Sept. 4** 19**48**, to **Sept. 13** 19**48**
that I last saw h^e alive on **Sept. 13** 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Embolism - Pulmonary** Duration **1/2 hr.**

Due to

Due to

Other conditions **Pregnancy 9 months**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **1478**

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 **Arthur E. ...** (M. D. or other) **11.17**

Address **St. Genevieve Mo** Date signed **9-14-48**

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

RECEIVED

Sanitary Health Officer No. 4
File Number 1048-12
Date 10-1-48

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 Elton H. Remelius

Licensed Embalmer No. 4283

P. O. Address St. Louis 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.

Registration District No. 279 Primary Registration District No. 4468

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 years, months or days)

3. (a) PRINT FULL NAME Altha Coffman

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

4. Sex F 5. Color or race B. 6. (a) Single, widowed, married, divorced. m

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. Year

7. Birth date of deceased May 29
(Month) (Day) (Year)

8. AGE: Years 23 Months 3 Days 3 If less than one day hr. min.

9. Birthplace Mo.
(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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April 13
year 1947 hour 13 minute M.

21. I hereby certify that I attended the deceased from 9 to 19 that I last saw him alive on 19 and that death occurred on the date and hour stated above.
Immediate cause of death

Duration

Due to There was no delivery or abortion within 28 days before death, which was from Coronary embolism. The fetus was removed by the undertaker from dead mother after death of both mother

Other conditions (Include pregnancy within 3 months of death)

Major findings: and factors.

Of operations OK

Of autopsy OK

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 Arthur Sawyer (M. D. or other) M.D.
Address St. Genevieve Mo Date signed 10-15-48

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

SUPPLEMENTARY

S-31675