

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **41726**
Registrar's No. **434**

FILED DEC 19 1949

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

BIRTH MO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>434</u>	
1. PLACE OF DEATH a. COUNTY Marion				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hannibal		3 _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION Levering Hospital				d. STREET ADDRESS (If rural, give location) 201 South Locust			
3. NAME OF DECEASED (Type or Print) Emma Coffman			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) December 6, 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH April 15, 1876		9. AGE (In years) (Month) (Day) 73	IF UNDER 1 YEAR (Months) (Days) _____	IF UNDER 24 HRS. (Hours) (Min.) _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Knox County Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Henry Taylor Bledsoe			13b. MOTHER'S MAIDEN NAME Carolyn Mason			14. NAME OF HUSBAND OR WIFE No record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME Her personal Record ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) Hypertension & Arterio-sclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH 2 days 331X	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Dec. 5, 1949</u> , to <u>Dec. 6, 1949</u> , that I last saw the deceased alive on <u>Dec. 6, 1949</u> , and that death occurred at <u>8:24 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <i>[Signature]</i> (Degree or title) M.D.				23b. ADDRESS Hannibal, Mo.		23c. DATE SIGNED 12-12-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/8/49	24c. NAME OF CEMETERY OR CREMATORY Mount Olive		24d. LOCATION (City, town, or county) (State) Hannibal Missouri		
DATE REC'D BY LOCAL REG. 12-13-49		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Hannibal Missouri			

RECEIVED DEC 15 1949
MARIC V. HEALTH DEPT.
DATE FILED DEC 15 1949

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.....

....., Student Embalmer No.

working under my personal supervision.

Signed.....

John S. Ward

Licensed Embalmer No. 4540

Signed.....
Student Embalmer

P. O. Address Hannibal Missouri

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.