

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **45243**
Registrar's No. **12402**

FILED JAN 19 1954

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>2247</u>			
b. CITY OR TOWN <u>ST. LOUIS MO</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>3946 MINNESOTA</u>				e. STREET ADDRESS (If rural, give location) <u>24 3946 MINNESOTA</u>			
3. NAME OF DECEASED (Type or Print) <u>ELBERT J COFFEE</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 30 1953</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN. 21 1896</u>		9. AGE (In years last birthday) <u>63</u>	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) <u>MAINTENANCE FORMAN MONSANTO</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? _____
13a. FATHER'S NAME <u>JOHN J. COFFEE</u>		13b. MOTHER'S MAIDEN NAME <u>SERENA RAMAGE</u>		14. NAME OF HUSBAND OR WIFE <u>FRANCES COFFEE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW #1</u>		16. SOCIAL SECURITY NO. <u>493-10-4766</u>		17. INFORMANT'S SIGNATURE OR NAME <u>ELVIE C. COFFEE</u> ADDRESS <u>2474 ARLINGTON</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>myocarditic chronic</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchial Asthma</u> DUE TO (c) <u>Hypertrophic Cirrhosis of Liver</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Don't Know</u> <u>Don't Know</u>	
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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5810</u>			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>44</u> , to <u>Dec 29</u> , 19 <u>53</u> ; that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>53</u> , and that death occurred at <u>10 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John J. Coffey MD</u>				23b. ADDRESS <u>5051A GRAVIER ST. ST. LOUIS 12-31-53</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JAN. 2 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>FAMILY LOT ST. PAUL INDIANA</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>JAN 2 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kulis 2906 Gravier</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

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..

Student.....
Signature of Student Embalmer

Signed *James C. Will*.....

Licensed Embalmer No. *434*

P. O. Address *2906*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.