

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15595**

FILED JUN 11 1956

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

BIRTH NO. _____		REG. DIST. NO. <b>42</b>		PRIMARY REG. DIST. NO. <b>1000</b>		Registrar's No. <b>614</b>			
1. PLACE OF DEATH a. COUNTY <b>BUCHANAN</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MO</b> b. COUNTY <b>BUCHANAN</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. JOSEPH,</b>		c. LENGTH OF STAY (In this place) <b>3 Weeks</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. JOSEPH</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Northwest Missouri Nursing Home</b>				d. STREET ADDRESS (If rural, give location) <b>1029 DOUGLAS St. 227 W. NEBRASKA Ave.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>SARAH</b>			b. (Middle) <b>BELLE</b>		c. (Last) <b>COFFEE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 5, 1956</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>AUG. 12, 1869</b>	9. AGE (In years) If birthday: Months <b>9</b> Days <b>23</b>	IF UNDER 1 YEAR Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>FAYETTE, MO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>UNKNOWN</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>BEN COFFEE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>ETHEL GOODALL 227 W. NEBRASKA ST. JOSEPH, MO.</b>					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CARDIO-RENAL-VASCULAR COLLAPSE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <b>SENILITY</b>				DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>442X</b>						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?					
22. I hereby certify that I attended the deceased from <b>NOV. 1, 1954</b> , to <b>JUNE 5, 1956</b> , that I last saw the deceased alive on <b>JUNE 5, 1956</b> , and that death occurred at <b>7:50 Am.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <i>E. Brown</i>				23b. ADDRESS <b>5105 KING HILL AVE ST. JOSEPH, 48, MO.</b>		23c. DATE SIGNED <b>6-6-56</b>			
24a. BURIAL, CREMATION, OR DISPOSAL (Specify)		24b. DATE <b>6-7-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Ashland</b>		24d. LOCATION (City, town, or county) (State) <b>St. Joseph MO.</b>			
DATE REC'D BY LOCAL REG. <b>June 8, 1956</b>		REGISTRAR'S SIGNATURE <i>Kathleen M. Allison</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Beatrice Gray</i>		ADDRESS <b>812 Pacific</b>			

**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 .....  
Student Embalmer

Signed \_\_\_\_\_

*Bill J. Chaney*

Licensed Embalmer No. \_\_\_\_\_

*4679*

P. O. Address \_\_\_\_\_

*St. Joseph, 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.