

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-012175  
STATE FILE NUMBER

FILED APR 27 1959 Registration District No. 002 Primary Registration District No. 4009 Registrar's No. 25

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Savannah</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Savannah</u> 0020 00.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>204 So. 6<sup>th</sup> St.</u>		Length of stay in lb <u>35 years</u>	d. STREET ADDRESS (If outside, give location) <u>204 South 6<sup>th</sup> St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Isaac Thompson Coffey</u>			4. DATE OF DEATH Month Day Year <u>April 19, 1959</u>		
--	--	--	---	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	08. DATE OF BIRTH <u>October 22, 1865</u>	9. AGE (In years last birthday) <u>93</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
-----------------------	----------------------------------	---	--	--	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (RETIRED)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Andrew Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>George Thomas Coffey</u>	13b. MOTHER'S MAIDEN NAME <u>Kate Thompson</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>George Coffey</u>	Address <u>Savannah, Mo</u>
--	--	---------------------------------------	--------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>generalized arteriosclerosis</u>	<u>10 years</u>
	DUE TO (c) <u>arteriosclerotic gangrene of both feet</u>	<u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1/500</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	--	--	--

21. I attended the deceased from <u>April 5-5<sup>th</sup></u> , to <u>April 19 59</u> and last saw him alive on <u>April 18, 1959</u> Death occurred at <u>April 19, 1959 3:30 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>William O. Baker M.D.</u>	22b. ADDRESS <u>Savannah, Mo</u>	22c. DATE SIGNED <u>4-21-59</u>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-23-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Savannah City Cemetery</u>	23d. LOCATION (City, town, or county) <u>Savannah</u>	(State) <u>Mo</u>
--	-----------------------------	---	--	----------------------

24. FUNERAL DIRECTOR <u>W.A. Rich</u>	ADDRESS <u>Savannah, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>4-22-59</u>	26. REGISTRAR'S SIGNATURE <u>Lillian Parks</u>
--	--------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Wm A Rich* .....

Licensed Embalmer No. *4228* .....  
P. O. Address *Savannah,* .....

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.