

FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
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FILED VS OCT 4 1960

-60-037180

Registration District No. 381 Primary Registration District No. 6183 Registrar's No. FS

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Sullivan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Sullivan</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Milan</u>		Length of stay in 1b <u>5 yrs</u>		c. CITY OR TOWN <u>Milan</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Frazier Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Preston Coffman</u>				4. DATE OF DEATH Month Day Year <u>9 - 24 1960</u>									
5. SEX <u>m</u>		6. COLOR OR RACE <u>w</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-1882</u>		9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mental Patient</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Judson Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>					
13a. FATHER'S NAME <u>John A. Coffman</u>				13b. MOTHER'S MAIDEN NAME <u>Emily Armstrong</u>				14. NAME OF HUSBAND OR WIFE <u></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></u>		17. INFORMANT <u>Pete Coffman</u>		Address <u>Milan 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>Cerebral Hemorrhage</u>										INTERVAL BETWEEN ONSET AND DEATH <u>9-19-60</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Paraplegia</u>		<u>4-59</u>	
DUE TO (c) <u>Cerebral Hemorrhage</u>										<u>4-59</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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>9-19-60</u> to <u>9-24-60</u> and last saw ^{her} him alive on <u>9-22-60</u> Death occurred at <u>8 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>E. W. Simpson, D.O.</u> (Degree or title)						22b. ADDRESS <u>Milan, Mo</u>			22c. DATE SIGNED <u>9-24-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)					
<u>Burial</u>		<u>9-25-60</u>		<u>Thomas Union</u>		<u>Harris - Mo</u>							
24. FUNERAL DIRECTOR <u>Schwey's</u> ADDRESS <u>Milan Mo</u>				25. DATE RECD. BY LOCAL REG. <u>9-26-60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. M. W. Beckett</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Dwight Scherrel

Licensed Embalmer No. 2667

P. O. Address Windsor - N

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.