

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020162
STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 78

AMENDED FILED JUN 6 1961

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

HEARING SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		c. CITY OR TOWN <u>Springfield</u>	
Length of stay in 1b <u>6 yr, 1mo, 28da</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital No. 3</u>		d. STREET ADDRESS (If outside, give location) <u>State Hospital No. 3</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lafayette A. Coggin</u>			4. DATE OF DEATH Month Day Year <u>May 26 1961</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-16-82</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (City and state or country) <u>Greene County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>George W. Coggin</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Rose</u>	
14. NAME OF HUSBAND OR WIFE <u>Divorced</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>	
17. INFORMANT <u>Hospital Records</u>		Address	
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>Coronary occlusion</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
DUE TO (b) <u>Generalized arteriosclerosis</u>			Years
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fracture of right leg 4-17-61</u>			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>December 28, 1954</u> to <u>May 26, 1961</u> and last saw ^{her} him alive on <u>May 26, 1961</u> Death occurred at <u>8:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>F.L. Martin M.D.</u>		22b. ADDRESS <u>State Hospital #3, Nevada, Mo.</u>	22c. DATE SIGNED <u>5-26-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Republic, Mo</u>
24. FUNERAL DIRECTOR <u>W. A. Cantrell</u>	ADDRESS <u>Republic, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>May 31st 1961</u>	26. REGISTRAR'S SIGNATURE <u>Anna E. Perry</u>

JUL 25 1961

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 William B. Connett

Licensed Embalmer No. 4850

P. O. Address Republic, M.

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.