

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-045766

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSIDE OF

BY AFFIDAVIT OF

ITEM NO.

Registration District No. 273 Primary Registration District No. 3051 Registrar's No. 145

FILED DEC 19 1961

1. PLACE OF DEATH a. COUNTY <u>PERRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>PERRYVILLE</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>MINNITH</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>PERRY CO. MEMORIAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>ST MARYS MO STAR ROUTE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JERRY</u> Middle <u>EUGENE</u> Last <u>COFFMAN</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>7</u> Year <u>1961</u>			
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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>12/30/49</u>	9. AGE (last birthday) <u>11</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOLAR</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>CHESTER IL</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>EUGENE COFFMAN</u>	13b. MOTHER'S MAIDEN NAME <u>WILMA KRIETE</u>	14. NAME OF HUSBAND OR WIFE
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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.	17. INFORMANT <u>Eugene Coffman Minnith MO</u>	Address
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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>Acute tracheo bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18hr.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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>Hemoch's purpura</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
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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.)
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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
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21. I attended the deceased from 2-7-1956 to 12-7-1961 and last saw him alive on 10-7-1961
Death occurred at 3:00 P on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>J. E. Faschick, MD</u>	22b. ADDRESS <u>Perryville, Mo.</u>	22c. DATE SIGNED <u>12-15-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12/10/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MINNITH CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MINNITH</u>	(State) <u>MO</u>
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24. FUNERAL DIRECTOR <u>Lee C. Bach Sr., Hannibal Mo</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-16-61</u>	26. REGISTRAR'S SIGNATURE <u>Joseph Zollner</u>
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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 Heal. Barber

Licensed Embalmer No. 1985
P. O. Address St. Genevieve

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.