

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032355

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7611** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 31 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>PINE LAWN</b>	
Length of stay in lb <b>8 1/2</b> Hours		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital 925 N. Grand</b>		d. STREET ADDRESS (If outside, give location) <b>6913 Glenmore</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on-Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Amos Givens COFFEY</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>1,</b> Year <b>1962</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-30-90</b>	9. AGE (last birthday) <b>72</b>	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) <b>Plumber</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing Contr.</b>	11. BIRTHPLACE (City and state or country) <b>Cloquet, Minn.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
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13a. FATHER'S NAME <b>William Coffey</b>	13b. MOTHER'S MAIDEN NAME <b>Isabelle Shotley</b>	14. NAME OF HUSBAND OR WIFE <b>Ruth Coffey</b>
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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) <b>YES WW I</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Ruth Coffey 6913 Glenmore (20)</b>	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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<b>Acute Gastritis,</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	<b>Diabetes Mellitus,</b>	
DUE TO (b)	<b>Generalized Arterio Sclerosis</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)		PART III. If deceased was female was there a pregnancy in last 90 days. <b>260x</b>	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>12:30</b> Month, Day, Year <b>A</b>	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 <b>Jefferson Barracks, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at **12:30 A** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Helew L. Taylor, Coroner</b>	22b. ADDRESS <b>1300 Clark Ave.</b>	22c. DATE SIGNED <b>8-3-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug 6, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery Jeff. Bks. Jefferson Barracks, Mo.</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>Robert J. Donnelly</b>	ADDRESS <b>3840 Lindell Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 3 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

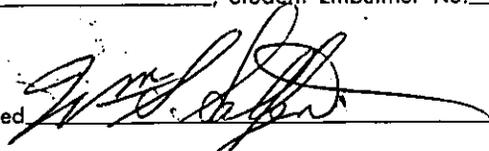
USE BLACK INK OR TYPEWRITER RIBBON

CORONER'S  
OFFICE

**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  \_\_\_\_\_

Licensed Embalmer No. 4689

P. O. Address 5845 Lindell

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.