Form V. S. 1—25m—1-4-23

COMMONWEALTH OF KENTUCKY
State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

File No. 7519
Registered No. 75

1 PLACE OF DEATH
County Muhlenberg
Vot. Pct.
Inc. Town Central City
City
Registration District No. 1057
Primary Registration District No. 2435
(No. St., Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dr. William Calvin Coffman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single / Married / Widowed / or Divorced (Write the word): Married

6 DATE OF BIRTH: Sept 7, 1865 (Month) (Day) (Year)

7 AGE: 58 yrs. 6 mos. 8 ds.
IF LESS than 1 day ____ hrs. or ____ min?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry, business or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Ky

PARENTS

10 NAME OF FATHER: Edson Allen Coffman
11 BIRTHPLACE OF FATHER (State or country): Ky
12 MAIDEN NAME OF MOTHER: Susan Henry
13 BIRTHPLACE OF MOTHER (State or country): Ky

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. C. Coffman
(Address) Central City

15 Filed 3/15, 1924. A. L. Blankenship Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 15, 1924 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-2-, 1924, to 2-15-, 1924, that I last saw h— alive on 2-15-, 1924, and that death occurred on the date stated above at 12 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. H. Foley M. D.
____, 192__ (Address) Central City Ky

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
at place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted,
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Fairmount
DATE OF BURIAL: Feb 17, 1924

20 UNDERTAKER: Moore Und Co
ADDRESS: Central City Ky

11—2184

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD