

Registration District No. 399 **FILED AUG 14 1940** Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 23 days  
In this community Unknown  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1205 Troost Avenue  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 29th  
year 1940 hour 9 minute 05 P M.  
21. I hereby certify that I attended the deceased from  
July 6th, 1940, to July 29th 1940,

that I last saw him alive on July 26th 1940, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Post operative 7<sup>th</sup> & 3<sup>rd</sup>  
lumbar sympathectomy  
for Berge's disease  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 876

Duration

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(a) Method of injury \_\_\_\_\_

23. Signature Dr. R. H. Shaw (M. D. or other)  
Address Med. Dir. K. C. Gen. Hospital Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

8. (a) PRINT FULL NAME LEO COTEY 300

8. (b) If veteran, name war No 8. (c) Social Security No. unk

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Gaile Cotey 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Dec - 24 1889  
(Month) (Day) (Year)

8. AGE: Years 50 Months 7 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Chicago  
(City, town, or county) (State or foreign country)

10. Usual occupation Bar tender

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Gaile Cotey

(b) Address Sedalia mo

17. (a) Buried (b) Date thereof aug-1-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn

18. (a) Signature of funeral director A. P. Doehler  
(b) Address 1415 East 15

19. (a) July 30, 1940 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

DATE OF DEATH  
BY WHOM

PLACE HERE TO RECORD THE NAME OF THE

TO BE  
BY WHOM  
PLACE HERE TO RECORD THE NAME OF THE

NAME OF THE  
PLACE HERE TO RECORD THE NAME OF THE  
PLACE HERE TO RECORD THE NAME OF THE

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**