

FILED OCT 11 1940

Registration District No. **399**

Primary Registration District No. **1002**

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:
11 East 32nd Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7**
(Specify whether
In this community **8 Years**
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. **11 East 32nd Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **--** years.

3. (a) PRINT FULL NAME

Mr. Manford Coffey

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Mrs. Mary Ellen Coffey**
6. (c) Age of husband or wife if alive **Unk.** years
7. Birth date of deceased **March 23 1873**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 5 23 hr. min.

9. Birthplace **Ravenwood Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **--**

MOTHER FATHER { 12. Name **William W. Coffey**
13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
14. Maiden name **Eliza Anderson**
15. Birthplace **Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Prof. C. Coffey**
(b) Address **814 W. Anderson**

17. (a) **Burial** (b) Date thereof **Sept. 18, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **W.H. Memorial Park**

18. (a) Signature of funeral director **O. H. Yucumich**
(b) Address **1401 Brush Creek Blvd.**

19. (a) **Sept. 16, 1940** (b) **M. M. Crove**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **15th**
year **1940** hour **7** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **about Sept. 1st** to **Sept. 15th**, 19 **40**
that I last saw him alive on **Sept. 14th**, 19 **40**;
and that death occurred on the date and hour stated above.

Immediate cause of death **CEREBRAL HEMORRHAGE**

Due to _____

Due to _____

Other conditions **820**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy **None**

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) Means of injury _____

23. Signature **Drury R. How** (M. D. or other)
Address **Med. Dir. K.C. Gen. Hospital** Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

Mr. Foley
Coffey
Genl Hosp

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.....

Emile M. Calhoun

Licensed Embalmer No. *3506*

P. O. Address *K. C. Mo*

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, fact should be so stated above.

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 3104429

V. S. No. 300
REV. 10-48

BIRTH NO. _____		REG. DIST. NO. <u>149</u>	PRIMARY REG. DIST. NO. <u>1002</u>	Registrar's No. <u>3607</u>
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)		
a. COUNTY <u>Jackson</u>		a. STATE _____ b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) _____		
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) _____		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				
3. NAME OF DECEASED			4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>Manford</u>			September 15, 1940	
b. (Middle) <u>- - -</u>				
c. (Last) <u>Coffey</u>				
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	
			9. AGE (In years last birthday) _____	
			IF UNDER 1 YEAR _____	
			IF UNDER 24 HRS. _____	
			Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
				12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME
(If yes, give war or dates of service)				ADDRESS
18. CAUSE OF DEATH		MEDICAL CERTIFICATION		
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES _____		
		DUE TO (b) _____		
		DUE TO (c) _____		
		II. OTHER SIGNIFICANT CONDITIONS		
		Conditions contributing to the death but not related to the disease or condition causing death _____		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.				
23a. SIGNATURE		23b. ADDRESS		23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reinterment</u>		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY
				<u>Green Lawn Cemetery</u>
24d. LOCATION (City, town, or county) (State)				
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE
<u>9-16-1940</u>		<u>M. M. Crowe</u>		ADDRESS

SUPPLEMENTARY

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

(Signature) Embellisher's Statement on Reverse Side)

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 _____
Student Embalmer

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, fact should be so stated above.