

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41618**
Registrar's No. **5325**

Registration District No. **199**

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: **Broose Nursing Home**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 Mo**
(Specify whether years, months or days) **40 YEARS**

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. **902 ARMOUR BLVD**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME **ALBERT FRANKLIN COUGHENOUR**

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **16TH** year **1947** hour **5** minute **55 P.M.**

4. Sex **MALE** 5. Color or race **WHITE**

6. (a) Single, widowed, married, divorced **DIVORCED**

6. (b) Name of husband or wife **Unknown**

6. (c) Age of husband or wife if alive **18** years

7. Birth date of deceased **MAY 28 1879**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **FEB 7 1942** to **DEC. 16 1947**

that I last saw **him** alive on **DEC. 16 1947** and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **6** Days **18**
If less than one day hr. min.

Immediate cause of death **LA PERITONSION**

Due to

Due to

9. Birthplace **Mc CRACKEN KANSAS**
(City, town, or county) (State or foreign country)

Other conditions **LEPE CEREBRO**
(Include pregnancy within 3 months of death) **LD CA**

10. Usual occupation **HOME BUILDER**

11. Industry or business **CONTRACTOR**

12. Name **UNKNOWN COUGHENOUR**

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)

Major findings: **THROMBOSIS**

Of operations **835**

Of autopsy

16. (a) Informant **ALLEN COUGHENOUR**

(b) Address **7433 MADISON AVENUE**

17. (a) **BURIAL** (b) Date thereof **12-19-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. MORIAN**

18. (a) Signature of funeral director **D. W. Newcomer, Son**

(b) Address **1401 Brush Creek Blvd**

19. (a) **12-19-47** (b) **Heraldine Holmes**
(Date received local registrar) (Registrar's signature)

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? **While at work?**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

23. Signature **D. S. [Signature]** (M. D. or other) **M. D.**

Address **1401 Brush Creek Blvd** Date signed **12-19-47**

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

MOTHER FATHER

6949 Prospect

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 Edmund W. Shuy
Licensed Embalmer No. 1767
P. O. Address Kansas City

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.