S. No. 300
M—10-47
v. 5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 7 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 16430

Registrar's No. 2239

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: 3303 Prospect /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson 48

(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No.: 3303 Prospect 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Lissie N. McCoy

3. (b) If veteran, name war: — no

3. (c) Social Security No.: 496-10-1415

4. Sex: Female /

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Art McCoy

6. (c) Age of husband or wife if alive: — years

7. Birth date of deceased: April (Month) 18 (Day) 1880 (Year)

8. AGE: Years 68 Months 1 Days 29 If less than one day ____ hr. ____ min.

9. Birthplace: Norfolk (City, town, or county) Nebr. / (State or foreign country)

10. Usual occupation: housewife

11. Industry or business: ____

MOTHER FATHER

12. Name: John Clemmons 9

13. Birthplace: unknown (City, town, or county) / (State or foreign country)

14. Maiden name: ____ 9

15. Birthplace: unknown (City, town, or county) / (State or foreign country)

16. (a) Informant: Mrs. Daisy L. Ford

(b) Address: 3428 Tracey

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 5-29-48 (Month) (Day) (Year)

(c) Place: burial or cremation: Green lawn Cem.

18. (a) Signature of funeral director: Mrs. C. L. Forster

(b) Address: 918 Brooklyn, K.C., Mo

19. (a) 5-28-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27th. year 1948 hour 11:00 P.M. minute A.M.

21. I hereby certify that I attended the deceased from Dec. 24, 1941, to May 26, 1948, that I last saw her alive on May 26, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to	
Due to	
Other conditions: None (Include pregnancy within 3 months of death) 94	

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN — 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? ____ (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: D. M. Figuo (M. D. or other) M.D.

Address: 925 Argyle Bldg. K.C., Mo. Date signed: 5-27-48

(Licensed Embalmer's Statement on Reverse Side)

Dr. Nigro
Argyle Bldg.

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 Dean Owens

Licensed Embalmer No. 4280

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.