. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19424

FILED JUL 3 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2640

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town KC.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3927 Kenwood.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 30 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson 48
(c) City or town KC. 3
(If outside city or town limits, write "RURAL")
(d) Street No. 3927 Kenwood 8
(If rural, give location) 0
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lenora Coatsworth

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F!

5. Color or race w

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased July 2nd 1899
(Month) (Day) (Year)

8. AGE: Years 48 Months 11 Days 20 If less than one day ..... hr. ..... min.

9. Birthplace Texas 4
(City, town, or county) (State or foreign country)

10. Usual occupation Telephone Operator

11. Industry or business

FATHER
12. Name A. Hoffman
13. Birthplace Texas!
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Madeline Kinsel
15. Birthplace Texas!
(City, town, or county) (State or foreign country)

16. (a) Informant Roy Sullivan
(b) Address 3927 Kenwood

17. (a) Burial (b) Date thereof 6/25/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington Cem.

18. (a) Signature of funeral director Carroll Davidson
(b) Address 3024 Troost

19. (a) 6-24-48 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd
year 1948 hour 12 30 minute P M.

21. I hereby certify that I attended the deceased from Coroner, 19..., to ..... 19.....;
that I last saw h..... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fractured skull & neck	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 186a
Of autopsy no
History & Inspection

PHYSICIAN
Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident 23
(b) Date of occurrence 6-22-48
(c) Where did injury occur? KC Jackson Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home
(Specify type of place)
While at work? no (e) Means of injury Fall

23. Signature James Walker 3 (M. D. ~~or other~~) Coron
Address 1424 Prof Bldg Date signed 6-23-48.

Jefferson City Printing Co.

(Licensed Embalmer'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.....

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

working under my personal supervision.

Signed Kathryn E. Davids

Licensed Embalmer No. 3648

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.

S. No. 2B
—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 26x0

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lenora Coatsworth

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

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

7. Birth date of deceased July 2 1897
(Month) (Day) (Year)

8. AGE: Years 48 Months 1 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

SUPPLEMENTARY

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

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 (M. D. or other)

Address Date signed

S-19424