

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33787

State File No. _____

BIRTH NO. 72088-49 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4510

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Kansas City</u>	c. LENGTH OF STAY (In this place) <u>10/15-10/21</u>	c. CITY OR TOWN <u>Kansas City, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah</u>		d. STREET ADDRESS (If rural, give location) <u>6642 Pasco</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRED</u>	b. (Middle) <u>JAMES</u>	c. (Last) <u>COFFEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10 21 49</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>New Born</u>	8. DATE OF BIRTH <u>10-16-49</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u>	9b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>

13a. FATHER'S NAME <u>Frank James Coffey</u>	13b. MOTHER'S MAIDEN NAME <u>Billy Lee Roberts</u>	14. NAME OF HUSBAND OR WIFE <u>--</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Frank James Coffey</u>	ADDRESS <u>Mo. St. Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>renal failure</u>		MEDICAL CERTIFICATION (INTERVAL BETWEEN ONSET AND DEATH)
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) _____
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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? _____
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22. I hereby certify that I attended the deceased from 10/16, 1949 to 10/21, 1949 that I last saw the deceased alive on 10/21, 1949 and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. T. Van Der</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Kansas City, Mo.</u>	23c. DATE SIGNED _____
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE? <u>Oct 22, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Floral Hills</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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DATE REC'D BY LOCAL REG. <u>10-22-49</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Reed</u>	ADDRESS <u>K.C. Mo.</u>
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

Dr Van De

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 *Charles E. Mayfield*

Licensed Embalmer No. *4638*

P. O. Address *X.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.