

FILED OCT 22 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33792**
Registrar's No. **4273**

BIRTH NO. **57092-49** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1001**

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
d. FULL NAME OF HOSPITAL OR INSTITUTION Research Hospital		d. STREET ADDRESS (If rural, give location) 2101 S. 31st ST.	

3. NAME OF DECEASED (Type or Print) a. (First) Infant	b. (Middle)	c. (Last) Cossairt	4. DATE OF DEATH (Month) (Day) (Year) 10-3-49
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 10-2-49	9. AGE (In years last birthday) 15	IF UNDER 1 YEAR Months 15 Days 23	IF UNDER 12 HRS. Hours 15 Min. 23
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James McCreacken Cossairt	13b. MOTHER'S MAIDEN NAME Leota Irene Wagner	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME MR. JAMES COSSAIRT	ADDRESS 2101 S. 31st
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Preventable Premature		
	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 7025	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 **10-2-1949**, to **10-3-1949**, that I last saw the deceased alive on **10-3-1949**, and that death occurred at **1:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Robert F. Wortmann (Degree or title)	23b. ADDRESS 510 Professional Bldg.	23c. DATE SIGNED 10-3-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremated	24b. DATE 10-3-49	24c. NAME OF CEMETERY OR GREMATORY Research Hospital	24d. LOCATION (City, town, or county) (State) 23rd & Holmes Mo.
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DATE REC'D BY LOCAL REG. 10-16-49	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Research Hosp. N.C. Mo.	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed _____

Signed _____
Student Embalmer

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.