

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

296333

STATE FILE NUMBER

FILED AUG 28 1956

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 78

Health, Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Vernon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kansas City 3688</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #3</u> | | Length of stay in lb. <u>1 yr. 4 mo 11 days</u> | d. STREET ADDRESS <u>4017 Bellemore</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>Courtney</u> Last <u>Coffeen</u> | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>19</u> Year <u>1956</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec 21, 1981</u> |
| 9. AGE (In years last birthday) <u>73</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u> | 11. BIRTHPLACE (City and state or country) <u>Conceptionville, Iowa</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>unk.</u> | |
| 14. MOTHER'S MAIDEN NAME <u>unk.</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. <u>unk.</u> | | 17. INFORMANT <u>State Hospital #3 Records, Nevada, Mo</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Chronic Myocarditis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Brain Syndrome Assoc. c Disturbance etc c psychosis 331X</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>several days</u> <u>several months</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | |
| 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. <u>none</u> | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u> | |
| 20f. CITY, TOWN, OR LOCATION <u>none</u> | | 20g. COUNTY _____ STATE _____ | |
| 21. I attended the deceased from <u>April 8, 1955</u> to <u>Aug 19, 1956</u> and last saw him alive on <u>Aug 19, 1956</u> Death occurred at <u>4:15 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Dress or title) <u>Lewis H Wright, M.D.</u> | | 22b. ADDRESS <u>State Hospital #3, Nevada Mo</u> | |
| 22c. DATE SIGNED <u>Aug 19, 56</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | |
| 23b. DATE <u>8-20-56</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Local Hospital</u> | |
| 23d. LOCATION (City, town, or county) <u>Kansas City, Mo</u> | | (State) _____ | |
| 24. FUNERAL DIRECTOR <u>Hays Funeral Service Inc.</u> | | ADDRESS <u>Nevada, Mo.</u> | |
| 25. DATE RECD. BY LOCAL REG. <u>8-22-'56</u> | | 26. REGISTRAR'S SIGNATURE <u>Anna G Ferry</u> | |

(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *H.H. Marmaduke*.....

Licensed Embalmer No. *2074*.....

P. O. Address *Wanda, Pa.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.