THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1957

STATE FILE NUMBER 24473

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3107

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Kansas City — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Gen. Hosp. # 1 — Length of stay in Ib: 87 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 623 Euclid — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: C. Last: Coombs

4. DATE OF DEATH: Month: July Day: 4 Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-11-1869

9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Stone Mason

11. BIRTHPLACE (City and state or country): Bolivar Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Combs

13b. MOTHER'S MAIDEN NAME: Mary Jane Slavens

14. NAME OF HUSBAND OR WIFE: Jessie M. Gray Combs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 497-26-5912

17. INFORMANT: Mrs. Jessie Combs Address: 440 Tullis

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bilateral bronchopneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

491 h

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 2, 1957, to July 4, 1957 and last saw him alive on July 4, 1957. Death occurred at 7:10 am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B. I. Burns M.D.

22b. ADDRESS: 24th & Cherry Sts.

22c. DATE SIGNED: 7/4/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: July 6, 1957

23c. NAME OF CEMETERY OR CREMATORY: Mt. Washington

23d. LOCATION (City, town, or county) (State): Kansas City, Missouri

24. FUNERAL DIRECTOR ADDRESS: Sheil Funeral Home K.C. Mo.

25. DATE RECD. BY LOCAL REG.: 7-5-57

26. REGISTRAR'S SIGNATURE: Neva Trueinhall

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

B. I. Burns!

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Richard E. Carroll

Licensed Embalmer No. 4928

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.