

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017665

FILED JUN 9 1959

Registration District No.

149

Primary Registration District No.

1002

STATE FILE NO.

2377

Registrar's No.

100
-57

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|--|--|--|---|---|---|
| 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, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hosp. | | Length of stay in 1b 40 YRS. | d. STREET ADDRESS 3818 Flora | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle E Last Coony | | | 4. DATE OF DEATH Month May Day 11 Year 1959 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 19, 1882 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED POLICE DEPT. | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) EDINA, MO. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME THEODOREA COONY | | 13b. MOTHER'S MAIDEN NAME ROSE NOLAN | | 14. NAME OF HUSBAND OR WIFE Olive Coony | |
| 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 36 6544 | 17. INFORMANT Address OLIVE COONY 3818 FLORA KANSAS CITY, MO. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis DUE TO (c) 4221 | | | | INTERVAL BETWEEN ONSET AND DEATH 6 wks. 6 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ① Duodenal Ulcer ② Emphysema and Pulmonary Fibrosis | | | | 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.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <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.) | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from April 3, 1959 to May 11, 1959 and last saw ^{her} alive on May 11, 1959 . Death occurred at 11:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE John B. Caldwell MD (Degree or title) | | | 22b. ADDRESS 306 E 12 St. Kansas City, Mo. | | 22c. DATE SIGNED 5/12/59 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE MAY 14, 1959 | 23c. NAME OF CEMETERY OR CREMATORY CALVARY | | 23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO. | |
| 24. FUNERAL DIRECTOR D.W. Newcomers Sons Kansas City, Mo. | | ADDRESS | 25. DATE RECD. BY LOCAL REG. 5-13-59 | 26. REGISTRAR'S SIGNATURE Irene Minshall | |

John K. Caldwell USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

THIS CERTIFICATE IS VALID ONLY IF PRINTED ON THIS FORM

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 *Vern Lawler*

Licensed Embalmer No. *4915*
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

