

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041934

FILED VS. NOV 17 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5325 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>10 days</u>		c. CITY OR TOWN <u>Slater</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>St. Mary's Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>227 Rich St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Royce</u> Middle <u>Coolley</u> Last <u>Coolley</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>1960</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>unk.</u>		
9. AGE (last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HR Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>M.M. & O. R.R.</u>		11. BIRTHPLACE (City and state or country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>unknown</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Neola Coolley</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Haines Mortuary, Slater, Mo.</u>			
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>Multiple pulmonary infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u>	
DUE TO (b) <u>Thrombus, right auricle</u>								
DUE TO (c) <u> </u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Polycythemia vera, cor pulmonale</u>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <u> </u> Month, Day, Year <u> </u> a.m. <u> </u> p.m. <u> </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.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <u>August 28, 1960</u> to <u>October 23, 1960</u> and last saw him alive on <u>October 23, 1960</u>				Death occurred at <u>3:00 p.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>J. B. Coates</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>306 E. 12th St., K. C., Mo.</u>			22c. DATE SIGNED <u>10-24-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-23-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u> </u>		23d. LOCATION (City, town, or county) (State) <u>Slater Mo</u>		
24. FUNERAL DIRECTOR <u>Haines Mortuary, Slater, Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>10-24-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Dwyer</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF E. CASLES

NOV 22 1960

AUG 29 1961

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John R. Sidman

Licensed Embalmer No. 453

P. O. Address Home

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