

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 19 1960

5986-60-045985 STATE FILE NUMBER

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

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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 | | | Length of stay in 1b 8 days | | c. CITY OR TOWN Raytown | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6615 E 12th Terr | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 7315 Erwin Rd | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First AGNES Middle _____ Last COLTON | | | | 4. DATE OF DEATH Month November Day 28 Year 1960 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7/12/1880 | 9. AGE (last birthday) 80 | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Parkville Mo. | | 11. BIRTHPLACE (City and state or country) Parkville Mo. | | |
| 12. CITIZEN OF WHAT COUNTRY USA | | | 13a. FATHER'S NAME Granville Owens | | 13b. MOTHER'S MAIDEN NAME Mary Sample | | 14. NAME OF HUSBAND OR WIFE James B Colton |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Katherine Lawless 6615 E 12 Terr | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Quantum and Defilatation DUE TO (b) Carcinomatosis DUE TO (c) Malignant Melanoma of Breast Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 wks 4 mo undetermined | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | 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 _____ a.m. _____ p.m. Month, Day, Year _____ | 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>11-27-60</u> to <u>11-28-60</u> and last saw her ^{her} _{him} alive on <u>11-27-60</u> Death occurred at <u>4:23 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>M.C. Coatney D.O.</i> (Degree or title) | | | | 22b. ADDRESS 6235 Truman Rd | | 22c. DATE SIGNED 11-29-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Dec 1 1960 | 23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cem | | 23d. LOCATION (City, town, or county) Kansas City Missouri (State) | | |
| 24. FUNERAL DIRECTOR Shell Funeral Home Kansas City Mo ADDRESS | | | | 25. DATE RECD. BY LOCAL REG. 11-29-60 | | 26. REGISTRAR'S SIGNATURE <i>H.L. Dwyer</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

M. C. Coatney



Jackson
 Kansas City
 DEPT OF HEALTH
 NOVEMBER 20 1957
 WHITE
 HOUSEWIFE
 GRAVILLIE OWENS
 NONE

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
 Signature of Student Embalmer

Signed Thomas B. Phil

Licensed Embalmer No. 4957

P. O. Address A. C. M.

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

Kansas City Missouri
 DEPT OF HEALTH
 NOVEMBER 20 1957
 WHITE
 HOUSEWIFE
 GRAVILLIE OWENS
 NONE