

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-025096
3564 STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 602 Registrar's No. _____

FILED AUG 8 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Linn	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 6 days	c. CITY OR TOWN MOUND 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 V A HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) VA HOSPITAL Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BEN Middle COFFEEN Last			4. DATE OF DEATH Month July Day 17 Year 1961
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-5-94
9. AGE (last birthday) 66		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) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mound City, Kansas
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Thomas Coffeen	
13b. MOTHER'S MAIDEN NAME Elizabeth Carnes		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. WWT	
17. INFORMANT VA Hospital Official Records, K.C. Mo.		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) Acute leukemia of stem cell type			INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis			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. attended attended the deceased from July 11, 1961 to July 17, 1961 and was present at death. Death occurred at 5:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) T J Fritzlen MD		22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 7-18-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-18-61	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) Mound City, Kansas
24. FUNERAL DIRECTOR D. W. Newcomer's Sons K.C.K.	ADDRESS	25. DATE RECD. BY LOCAL REG. 7-18-61	26. REGISTRAR'S SIGNATURE Ruth Long

AUG 10 1961

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 James T. Deane

Licensed Embalmer No. 4453

P. O. Address Hawaii

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.