

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001585

627

STATE FILE NUMBER

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

AMENDED

FILED FEB 15 1962

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 A. Black
 D.O.S.

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>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>2 1/2 yrs.</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>100 E. 36 St.</u>		d. STREET ADDRESS (If outside, give location) <u>100 E. 36 St.</u>	
3. NAME OF DECEASED (Type or print) First <u>MORRIS</u> Middle <u>W.</u> Last <u>COY</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-1887</u>
9. AGE (last birthday) <u>74 yrs.</u>		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) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state of country) <u>unknown</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>George W. Coy</u>	
13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Pearl F. Coy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Ralph Coy, K.C. 2000</u>		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) <u>Cerebral Vascular accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
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>1961, Mom</u> to <u>Feb 1, 1962</u> and last saw ^{her} him alive on <u>Jan 20, 1962</u> Death occurred at <u>1:55 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>A. Black M.D.</u>		22b. ADDRESS <u>924 Bldg Bldg K-C-6 Mo</u>	
22c. DATE SIGNED <u>2/2/62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
23b. DATE <u>2-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>-</u>	
23d. LOCATION (City, town, or county) <u>States, Mo</u>		23e. (State) <u>Mo</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Haines Funeral Home Mo</u>		25. DATE RECD. BY LOCAL REG. <u>2-3-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

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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 John R. Sidman
Licensed Embalmer No. 4531
P. O. Address Kansas City, 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.