

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-027904**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1184

<b>FILED AUG 5 1963</b>	
1. PLACE OF DEATH	
a. COUNTY <u>Greene</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>	a. STATE <u>Mo</u> b. COUNTY <u>Greene</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>801 East Delmar</u>	c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>801 East Delmar</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last	
<u>John Henry Cossity</u>	
4. DATE OF DEATH Month Day Year	
<u>Aug 1 1963</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>1/7/1878</u>
9. AGE (last birthday) <u>85</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>Printer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>
11. BIRTHPLACE (City and state or country) <u>Springfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>George Cossity</u>	13b. MOTHER'S MAIDEN NAME <u>Nora Gardner</u>
14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no none</u>	
17. INFORMANT <u>881 Whitlock Cossity Springfield, 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>Cerebral Vascular accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
DUE TO (b) <u>Arteriosclerotic Vascular disease unknown</u>	
DUE TO (c) _____	
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.) <u>Springfield - Greene, Mo.</u>	
20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 5 '61</u> to <u>July 31 '63</u> and last saw <sup>her</sup> him alive on <u>July 31 '63</u>	
Death occurred at <u>3:55 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>609 Cherry</u>
22c. DATE SIGNED <u>Aug 1 1963</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE
<u>Funeral Removal</u>	<u>8/5/1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Marion Cemetery Kansas City, Missouri</u>	
24. FUNERAL DIRECTOR <u>Chapel of the Ozarks Inc.</u>	25. DATE RECD. BY LOCAL REG <u>8-2-63</u>
26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

8-2-63

**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 Horace B. Lewis

Licensed Embalmer No. 5159

P. O. Address / Springfield, 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.