

FILED MAR 24 1992

MISSOURI DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

DELAYED

STATE FILE NUMBER

REGISTRATION DISTRICT NO.

REGISTRAR'S NUMBER 235033

124 - 1912-041929

DO NOT WRITE
ON THIS STUB5a INSTRUCTIONS
7 - cy SEE OTHER SIDE
7 - st AND HANDBOOK.

9b DECEDENT

9c VS 300
Rev. 1/8910 MO 580-0695
(89)12a STATEMENT FROM DORIS
KANSAS CITY POST.13a THE OBITUARY - PASSED
FOR USE BY PHYSICIAN OR INSTITUTION
AWAY MARCH 16, 1992

13c & f

13e

13g

14

15

16

22b PARENTS

23u INFORMANT

23 - sc1

23 - sc2 DISPOSITION

27d

27e - f

27g - st

27g - co

27g - cy CAUSE OF
DEATH

29a

29b

FILED ON THE BASIS OF
A NOTARIALIZED
COPY OF THE
NEWSPAPER OF
THE
CAUSE OF
DEATH
A COPY FROM THE
COFFEYVILLE JOURNAL

CERTIFIER

1. DECEDENT'S NAME (First, Middle, Last) ROBERT F. COUK				2. SEX MALE		3. DATE OF DEATH (Month, Day, Year) March 16, 1912	
4. SOCIAL SECURITY NO.		5a. AGE - Last Birthday (Years) 72		5b. UNDER 1 YEAR MONTHS DAYS		5c. UNDER 1 DAY HOURS MINUTES	
6. DATE OF BIRTH (Month, Day, Year) April 22, 1840				7. BIRTHPLACE (City and State or Foreign Country) Jonesville, Lee Co. Virginia			
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.				9a. PLACE OF DEATH (check only one; see instructions on other side) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (specify)			
9b. FACILITY NAME (if not institution, give street and number)				9c. CITY, TOWN, OR LOCATION OF DEATH 1321 Paseo Kansas City,		9d. COUNTY OF DEATH Jackson	
10. MARITAL STATUS - Married, Never Married, Widowed, Divorced (Specify) Married		11. SURVIVING SPOUSE'S NAME (If wife, give full maiden name) ALMIRA Srepta SPRAGUE		12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired.) Bricklayer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. RESIDENCE - STATE MISSOURI		13b. COUNTY JACKSON		13c. CITY, TOWN, OR LOCATION KANSAS CITY		13d. ZIP CODE	
13e. STREET AND NUMBER 1321 PASEO				13f. INSIDE CITY LIMITS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		13g. YEARS AT PRESENT ADDRESS <input type="checkbox"/> Under 5 <input type="checkbox"/> 5-9 <input checked="" type="checkbox"/> 10-19 <input type="checkbox"/> 20 or more	
14. WAS DECEDENT OF HISPANIC ORIGIN (Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Specify:				15. RACE - American Indian, Black, White, etc. (Specify) White		16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
17. FATHER'S NAME (First, Middle, Last) DAVID COUK				18. MOTHER'S NAME (First, Middle, Maiden Surname) LAVINA MARTIN			
19a. INFORMANT'S NAME (Type/Print) DORIS JEAN COUK WRIGHT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5302 KISSING CAMELS DRIVE COLORADO SPRINGS, COLORADO 80904			
20a. BURIAL, CREMATION, OTHER (Specify) Buried (In Lot)		20b. DATE OF DISPOSITION (Month, Day, Year) Mar 21, 1992		20c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) OAK GROVE CEMETERY		20d. LOCATION - City or Town, State KANSAS CITY, MISSOURI	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH				22a. NAME AND ADDRESS OF FACILITY C.L. Forester Funeral Home (Purchased by DW Newcomers's		22b. FUNERAL ESTABLISHMENT LICENSE NUMBER	
23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death)		a. Stroke of Paralysis					
Due to (or as a consequence of):		b. DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST		c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.				25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY M		27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	
27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.				27e. DESCRIBE HOW INJURY OCCURRED			
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify)				27g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
28a. (Specify)		28b. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) ▶				28c. DATE SIGNED (Month, Day, Year)	
<input type="checkbox"/> CERTIFYING PHYSICIAN		<input type="checkbox"/> MEDICAL EXAMINER/CORONER				28d. TIME OF DEATH M	
29a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)				29b. MO. LICENSE NUMBER		30. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)				32. REGISTRAR'S SIGNATURE ▶		33. DATE RECEIVED BY LOCAL REGISTRAR (Month, Day, Year)	

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 _____

Licensed Embalmer No. _____

P.O. Address _____

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.

INSTRUCTIONS FOR SELECTED ITEMS

Item 9a - Place of Death

If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Item 13a-g - Residence of Decedent

Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home state," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence. If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13g. If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Item 23 - Cause of Death

The cause of death means the disease, abnormality, injury or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In Part I the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify. In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

SEE EXAMPLES BELOW.

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	Rupture of myocardium DUE TO (OR AS A CONSEQUENCE OF):			Mins.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b.	Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):			6 days	
	c.	Chronic ischemic heart disease DUE TO (OR AS A CONSEQUENCE OF):			5 years	
	d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	
Diabetes, Chronic obstructive pulmonary disease, smoking					25a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
					25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) _____	27b. TIME OF INJURY _____	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED _____	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify) _____			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____			

CAUSE OF DEATH

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	Cerebral laceration DUE TO (OR AS A CONSEQUENCE OF):			10 mins.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST	b.	Open skull fracture DUE TO (OR AS A CONSEQUENCE OF):			10 mins.	
	c.	Automobile accident DUE TO (OR AS A CONSEQUENCE OF):			10 mins.	
	d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24. IF DECEASED WAS FEMALE 10-49, WAS SHE PREGNANT IN THE LAST 90 DAYS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	
					25a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
					25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined <input type="checkbox"/> Homicide	27a. DATE OF INJURY (Month, Day, Year) 11/15/85	27b. TIME OF INJURY 1 p. M.	27c. WAS INJURY ALCOHOL-RELATED? (Not limited to decedent) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	27d. INJURY AT WORK? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unk.	27e. DESCRIBE HOW INJURY OCCURRED 2-car collision-driver	
27f. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (specify) Street			27g. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 4, Jefferson City, Missouri			