

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8301

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1005
 City Kansas City (No. 4011) Hyde Park

File No. _____
 Registered No. 11555
 St. _____ Ward _____

2. FULL NAME

John Bates Coggswell

(a) Residence, No. 4011 Hyde Park St. _____ Ward _____
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Bill Coggswell

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7-11-1850

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>76</u>	<u>8</u>	<u>6</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Conn.
 (STATE OR COUNTRY)

10. NAME OF FATHER Hiram H. Coggswell

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Conn.
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Betsy Bates

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Conn.
 (STATE OR COUNTRY)

14. INFORMANT Geo. Newman
 (Address) 208 West 62nd Ter.

15. FILED 3/18 27 M.M. Browne
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-17 1927

17. I HEREBY CERTIFY, That I attended deceased from 3/15, 1926, to 3-17, 1927
 that I last saw alive on 3-17, 1927, and that death occurred, on the date stated above, at 3:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral apoplexy (stroke)
 (duration) yrs. 5 mos. ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
Several years (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH, _____

18 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) J.M. Perkins, M.D.
3/18, 1927 (Address) 3827 E. 9th

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Coplin Mo. DATE OF BURIAL 3/19 1927

20. UNDERTAKER Stine & McClure ADDRESS 924 Oak

FADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Dr. Perkins
203 Angyle

Nov. 9 485-

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