

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 99

Do not use this space.

27895
3587

1. PLACE OF DEATH
 County Jackson Registration District No. 1002
 Township Kaw Primary Registration District No. _____
 City Kansas City (No. St. Lukes Hospital) _____ St. _____ (Ward)

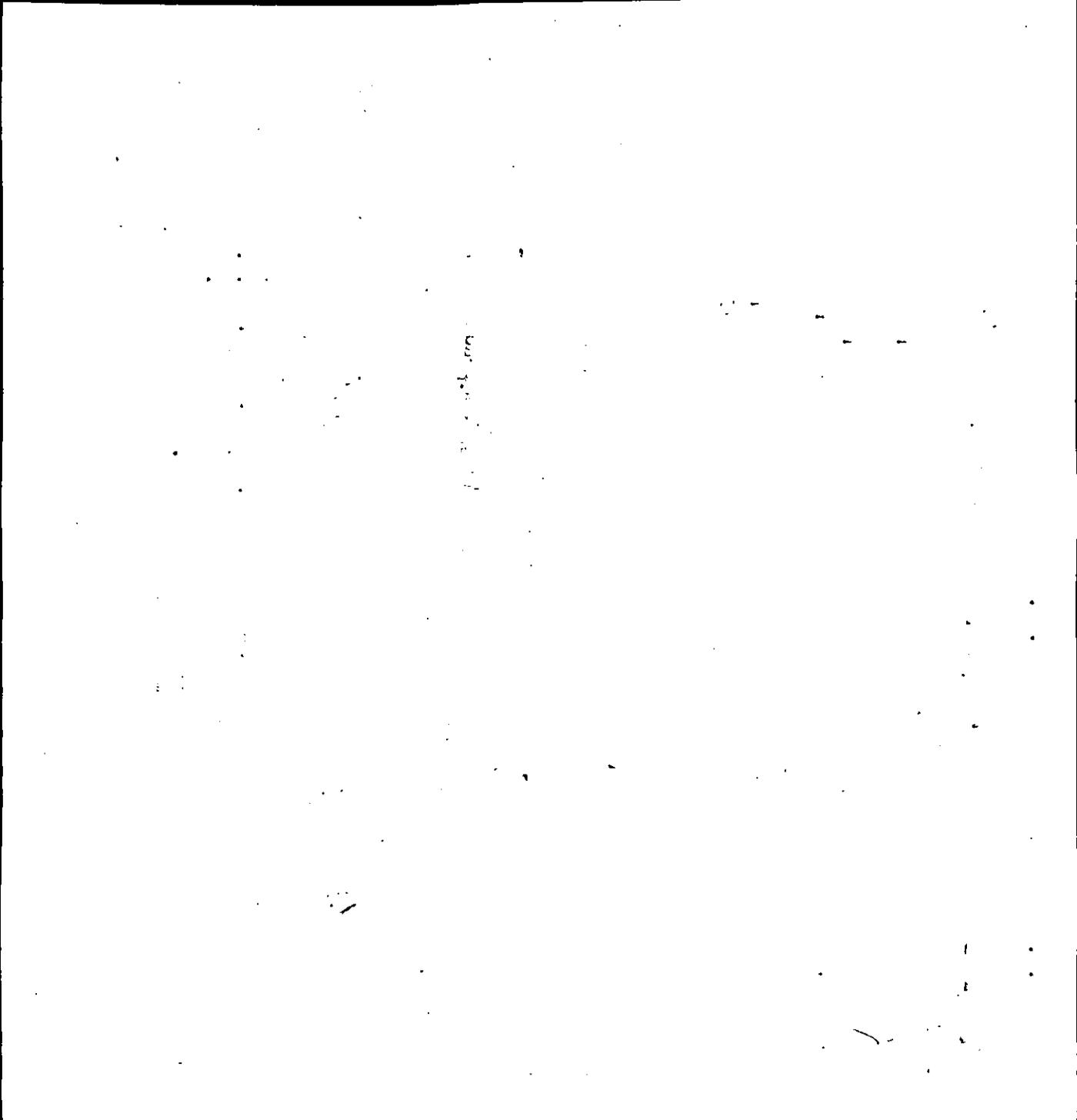
2. FULL NAME James V. Coburn
 (a) Residence. No. R.R. #2, Kansas City, Mo. Ward. _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3. SEX Male	4. COLOR OR RACE White	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Divorced		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Daisy Coburn				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 4 1867				
7. AGE	YEARS 61	MONTHS 9	DAYS ?	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____				

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Ohio	
PARENTS	10. NAME OF FATHER Don't know
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know
	12. MAIDEN NAME OF MOTHER Don't know
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know

14. INFORMANT <u>Virgil C. Coburn</u> (Address) <u>516 W. West Hutchinson St.</u>
15. FILED <u>8/23 1929</u> <u>M. M. Crowe</u> REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
16. DATE OF DEATH (MONTH, DAY AND YEAR) <u>8/21 1929</u>	
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.	
THE CAUSE OF DEATH* WAS AS FOLLOWS: <u>accidental fractured pelvis, with hemorrhage</u>	
CONTRIBUTORY (SECONDARY) <u>Rock fall on hip</u> <u>shelcropping</u> (duration) <u>2 1/2</u> yrs. <u>10</u> mos. <u>10</u> ds.	
18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH _____	
DID AN OPERATION PRECEDE DEATH? <u>no</u> DATE OF _____	
WAS THERE AN AUTOPSY? <u>yes</u>	
WHAT TEST CONFIRMED DIAGNOSIS? <u>autopsy</u> (Signed) <u>Stanley M. Hales</u> , M. D. <u>8/23 1929</u> (Address) <u>Deputy Coroner</u>	
*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hutchison, Kansas	DATE OF BURIAL 8-23-29 19
20. UNDERTAKER R. V. LINDSEY & SONS, Inc	ADDRESS K.C. Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. *399*
 Township..... Primary Registration District No. *112*
 City *St. Louis* (No.....) St. *11* (Ward)

File No.....
 Registered No. *33-89*

2. FULL NAME

(a) Residence. No..... St..... Ward.....
 (Usual place of abode) (If nonresident, give city or town and State)
 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 *M* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *div*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT..... (Address).....

15. FILED *9/23/29* *M. M. Crowe* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9/21/29*

17. I HEREBY CERTIFY That I attended deceased from..... to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental fractured pelvis
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) *Rich fell on him while working in quarry*
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? *117*

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) *Stanley M. Hall*, M. D.

, 19..... (Address) *117 E. Olive*

*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 DATE OF BURIAL

20. UNDERTAKER ADDRESS

THIS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-27895