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

Do not use this space. 27942 3636

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. — Registered No.
City Kansas City (No. General Hospital 1002 St. Ward)

2. FULL NAME Joseph E. McCoy
(a) Residence. No. 1515 Crystal St., 12 Ward. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 17th, 1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	57	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Special Officer
(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) Not known

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Not known

14. INFORMANT Coroner's record
(Address) K C Mo

15. FILED 8/26 1929 M. M. Crowe asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/25 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., 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 Auto mobile Injuries K. C. Mo.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) 1880
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) Sherry L. Hall, M. D.
8/26 1929 (Address) Deputy Coroner

*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 Mt. Washington — DATE OF BURIAL Aug 26 1929
20. UNDERTAKER R. V. Lindsey & Sons, Inc. — ADDRESS K. City, Mo.

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.

WRITE PLAINLY, WITH INDIAN INK—THIS IS A PERMANENT RECORD

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