

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1-41931

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.

Registration District No. 399 Primary Registration District No. 1002

1. PLACE OF DEATH: 2
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 3434 Penn
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community all life
years, months or days

3. (a) PRINT FULL NAME ROBERT J. COFFEY 170
 (b) If veteran, name war No. (c) Social Security No. ✓

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced No
 (b) Name of husband or wife Mrs. Catherine Coffey 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased August 24, 1876
(Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 8 If less than one day
 hr. _____ min.

9. Birthplace St. Joseph, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Police Chief (Retired)

11. Industry or business K. C. Police Dept. 0

12. Name Timothy Coffey 5

13. Birthplace Ireland 5
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Bailey
(City, town, or county) (State or foreign country)

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Catherine Coffey
 (b) Address 3434 Penn

17. (a) Burial (b) Date thereof 11-6-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Quick & Robin Co.
 (b) Address K.C. Mo

19. (a) Nov 3 1939 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits, write "RURAL")
 (d) Street No. 3434 Penn
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Nov 2nd Day 2nd
 year 1939 hour 12:10 minute 0 M.

21. I hereby certify that I attended the deceased from Nov 2, 1939
10 to Nov 2, 1939
 that I last saw him alive on Nov 12, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Heart Failure
 Due to hypertension

Due to 930

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)

While at work _____ (e) Means of injury 1

23. Signature W. F. ... (M. D. or other) _____
 Address 927. Argy 76 C. Mo Date signed 11/2/39

PHYSICIAN
 Underline the cause to which death should be charged statistically

Robert J Coffey

APR 17 1908

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.....

....., Registered Apprentice No.
working under my personal supervision.

Signed Maurice Maurik

Licensed Embalmer No. 2226

P. O. Address N. C. 7 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

38443
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson
(b) Township K.C.
(c) City K.C.

Registration District No. 399
Primary Registration District No. 1002

Registered No. 4207

(d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Robert J. Coffey

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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.
63 2 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

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

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Nov 3 1939 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 2 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____ (Signed) M. L. Gint, M. D.

(Address) 927 Oregon K.C. Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

