

No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
MED JUN 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17602
State File No.
Registrar's No. 2129

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(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: 7207 Wabash
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 36 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME MARY VIRGINIA COEN 500

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William H. Coen 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased April 21, 1857
(Month) (Day) (Year)

8. AGE: Years 83 Months 1 Days 1 If less than one day hr. min.

9. Birthplace Howard County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business 9

12. Name John Anderson

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

14. Maiden name Elsbeth Reyburn

15. Birthplace Don't Know
(City, town, or county) (State or foreign country)

16. (a) Informant Charles A. Coen
(b) Address 4430 Broadway

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 24, 1940
(Month) (Day) (Year)
(c) Place: burial or cremation Floral Hills Cemetery

18. (a) Signature of funeral director Freeman Mortuary

(b) Address 104 W. 42nd St., K.C., Mo.

19. (a) May 24, 1940 (Date received local registrar) (b) M. M. Craue (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 7207 Wabash
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 22 year 40 hour _____ minute _____

21. I hereby certify that I attended the deceased from 11:30 P. to _____, 1940;
that he did not live on _____, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death encephalomalacia
and occlusion of right middle cerebral vessel on right

Due to _____

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? _____
While at work? _____ (Specify type of place) (Specify type of injury)

23. Signature Doctor M. M. Craue (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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.....

Elmer C. Wecklin

Licensed Embalmer No.....

3495

P. O. Address.....

Kansas City 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.