

FILLED OCT 13 1941

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

30524
Do not use this space.
3281

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Raw Primary Registration District No. 100
(c) City Kansas City (d) Street No. St. Francis Registered No. 3281
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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

(a) Residence, No. 7211 Gardner (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-1-41
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
X 2 X + 3 hrs. 5 min.

OCCUPATION 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. None
10. Date deceased last worked at this occupation (month and year) + 11. Total time (years) spent in this occupation 2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

FATHER 13. NAME James R. Coole

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City, Mo.

MOTHER 15. MAIDEN NAME Mary Blumhardt

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

17. INFORMANT (ADDRESS) James Coole 4211 Gardner

18. BURIAL, CREMATION, OR REMOVAL PLACE Wentzons DATE Apr 2 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John A. Munn 1415 215

20. FILED 9/2 19 41 M. M. Brown Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-1 19 41

22. I HEREBY CERTIFY, That I attended deceased from 9-1, 19 41 to 9-1, 19 41
I last saw him alive on 9-1, 19 41. Death is said to have occurred on the date stated above, at 8:30 P.M.
The principal cause of death and related causes of importance were as follows:

Immunization + 9/1/41
Premature 7 1/2 mo.
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? no
If so, specify.....
(Signed) Dean D. Pringle M. D.
(Address) 1107 Bryant Bldg
KE 14

WRITE PLAINLY, WITH UNFADING 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.

91009

[Handwritten signature]

[Handwritten notes: 1-P, 1-A, 1-B]

[Handwritten note: 1-A]

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.....

Licensed Embalmer No.....

P. O. Address.....

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.