

FILED APR 25 1942

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 1373

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:  
Steva Convalescent Home 3241 Wabash  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 5 Days  
(Specify whether  
In this community 20 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson 042  
(c) City or town Kansas City 5  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 3223 Woodland  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Jennie M. Coles

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Harvey R. Cole 6. (c) Age of husband or wife if alive 22 years  
7. Birth date of deceased January 1860  
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 15 If less than one day  
--- hr. --- min.

9. Birthplace Syracuse New York  
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business \_\_\_\_\_

12. Name Mc Calough

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

14. Maiden name Unknown

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

16. (a) Informant Allen E. Coles

(b) Address 2701 N. W. 22 Okla. City, Okla

17. (a) Removal (b) Date thereof April 7 42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Seneca, Kansas

18. (a) Signature of funeral director Eylar Funeral Home  
(b) Address 1800 Linwood Blvd, K.C. Mo.

19. (a) 4-7-42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6  
year 1942 hour 10 minute 0 - P. M.

21. I hereby certify that I attended the deceased from March 9, 1942 to April 6, 1942  
that I last saw her alive on April 6, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemiplegia (Right)

Due to Terminal Broncho-Pneumonia

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations None

Of autopsy None

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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Heinrich A. Davis (M. D. or other) M.D.  
Address 3301 Woodland Date signed 4-7-42

Duration Since March 9, 1942  
Since April 5, 1942  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER

Kansas City, Mo.

**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.....

*Chas Wilks*

Licensed Embalmer No. ....

*2644*

P. O. Address.....

*1800 Luwo*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **1373**

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

**1. PLACE OF DEATH:**

(a) County.....

(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
**Steva Convalescent Home**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether

In this community.....  
years, months or days)

**3. (a) PRINT FULL NAME** **Jennie M. Coles**

**3. (b) If veteran,** name war..... **3. (c) Social Security No.**.....

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

**6. (b) Name of husband or wife**..... **6. (c) Age of husband, or wife, if** alive..... years

**7. Birth date of deceased**.....  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day

**82 yrs.** h..... min.

**9. Birthplace**.....  
(City, town, or county) or foreign country)

**10. Usual occupation**.....

**11. Industry or business**.....

**MOTHER** { **12. Name**.....

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

**14. Maiden name**.....

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

**16. (a) Informant**.....

**(b) Address**.....

**17. (a)**..... **(b) Date thereof**.....  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation**.....

**18. (a) Signature of funeral director**.....

**(b) Address**.....

**19. (a)** **6/10/42** **(b) M. M. Brown**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....

(c) City or town.....  
(If outside city or town limits write "RURAL")

(d) Street No.....  
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Month **April** day **6th**  
year **1942** hour..... minute..... M.

**21. I hereby certify that I attended the deceased from**..... 19..... to..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hemiplegia right**  
**Hemiplegia did not**  
**follow cerebral hemorrhage.**  
Due to **Terminal Broncho Pneumonia**

Due to.....

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

**Major findings:**  
Of operations.....

Of autopsy.....

**Duration**

**107**

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

**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)

(c) Means of injury.....

**23. Signature** **Rebecca A. Daw** (M. D. or other) **MD**  
Address **330 Woodland** Date signed **5-30-42**  
**Kansas City, Mo.**

9535