

FILED APR 25 1942

Registration District No. _____

Primary Registration District No. **6002**

Registrar's No. **1474**

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)
6430 E-13 St.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) **6 years**

3. (a) PRINT FULL NAME **Robert Wilson Coulter**
 3. (b) If veteran, name war **none**
 3. (c) Social Security No. **none**

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Daisy L. Coulter**
 6. (c) Age of husband or wife if alive **52** years
 7. Birth date of deceased **Aug. 13, 1881**
(Month) (Day) (Year)

8. AGE: Years **60** Months **7** Days **29**
If less than one day hr. min.

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

10. Usual occupation **none**

11. Industry or business _____
 12. Name **W. Scott Coulter**
 13. Birthplace **no record Ohio**
(City, town, or county) (State or foreign country)
 14. Maiden name **Ann Fakhram**
 15. Birthplace **Independence Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Daisy L. Coulter**
 (b) Address **6430 E-13 St.**

17. (a) **Burial** (b) Date thereof **4/14/42**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **See funeral home**

18. (a) Signature of funeral director **Geo. C. Carson**
 (b) Address **Independence Mo.**
 19. (a) **4-14-42** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

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. **6430 E-13 St.**
(If rural, give location)
 (e) Citizen of foreign country? **no** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Apr** day **12**
 year **1942** hour **3** minute **9** P.M.
 21. I hereby certify that I attended the deceased from **Mar 15, '42**
 _____, 19____ to **Apr. 12, 1942**
 that I last saw him alive on **4-12-42**
 and that death occurred on the date and hour stated above.

Immediate cause of death. **Cardiac failure**
& cor pulmonale
 Due to **Emphysema**
(asthmatic)
 Due to _____

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

Major findings: Of operations **none** **110a**
 Of autopsy **yes**
 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?

(Specify type of place) (e) Means of injury _____
 While at work? _____
 23. Signature **Ed Kueer** (M. D. or other) _____
 Address **920 Newton K.C. Mo.** Date signed **4/13/42**

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 complete the above constitutes grounds for revocation of license.)

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 1474

1. PLACE OF DEATH:

(a) County

(b) City or town

(c) Name of hospital or institution:
6430 E. 13th Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No. 6420 E. 13th Street
(If rural, give location)

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

3. (a) PRINT FULL NAME Robert Wilson Coulter

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

4. Sex Male 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..... year.....

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

8. AGE: Years Months Days If less than one day
60 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.....
6/10/42 (c) M. M. Grove
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12th
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 cardiac failure, Congestive
Duration.....

Due to.....
Congestive

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death) 935

Major findings:
Of operations.....

Of autopsy.....

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) (e) Means of injury.....

23. Signature..... L. E. Ebel (M. D. or other).....

Address..... Date signed.....

9540