

S. No. 2
FORM-2-43
REV. 5-17-39
I. x 117

33744

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

4355

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

NOV 1 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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: 1709 Washington
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 5 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Washington
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MATHEW COUGHLIN

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced unknown

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

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

8. AGE: Years 69 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____
MOTHER FATHER }
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 Coverman office MO
(b) Address K C

17. (a) Removal (b) Date thereof 10-13-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation K C College of Osteopathy

18. (a) Signature of funeral director John E. Bevers
(b) Address _____

19. (a) 10-13-43 (b) P. E. Bevers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 12
year 1943 hour 3 minute 10 P.M.

21. I hereby certify that I attended the deceased from _____
that I last saw him _____ alive on _____
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to _____
Due to 930

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

Major findings: Of operations _____
Of autopsy Aspiration & biopsy

Duration _____
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 Bevers (Date) 10/13/43
Address _____ Date signed _____

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 *Dean B. Lutzner*.....

Licensed Embalmer No. 4273.....

P. O. Address KCMO.....

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, fact should be so stated above.