

FILED DEC 22 1943

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 5129

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours
(Specify whether
In this community 55 years
years, months or days)

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. 4000 Campbell
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mrs Catherine M Coffey
3. (b) If veteran, name war No 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 Patrick 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 2, 1863
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>8</u>	<u>4</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name No Record
13. Birthplace County Galway, Ireland
(City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Thomas McCaffrey

(b) Address 4000 Campbell

17. (a) Burial (b) Date thereof 12/9/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Burke and Dolan Co.

(b) Address 20 W. Linwood, K. C., MO.

19. (a) 12-8-43 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 6th
year 1943 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Dec. 6, 1943 to Dec. 6, 1943

that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardia
Due to Ischemic Occlusion
Due to Coronary Arteriosclerosis

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

Major findings: g/a
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)
23. Signature Dr. John O. Jensen (M. D. or other) _____
Address 1402 N. 2nd St. K. C. MO Date signed _____

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

MOTHER FATHER

Duration
1 yr
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Charles M Zwick

Licensed Embalmer No. 3774

P. O. Address 44. Q 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, fact should be so stated above.