

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8525

921

FILED MAR 19 1945

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No.

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

1. PLACE OF DEATH: Jackson

(a) County Kansas City

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

(c) Name of hospital or institution: Osteopathic Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hour  
(Specify whether years, months or days)

In this community 2 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson

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

(d) Street No. 3718 E. 10 St  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sharron Bernice Coonfield

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 Single

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

7. Birth date of deceased: February 1940  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>5</u>	<u>0</u>	<u>13</u>	hr. _____ min. _____

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

10. Usual occupation None

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

12. Name Wayne C. Coonfield

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

14. Maiden name Marie Goetting

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

16. (a) Informant Wayne C. Coonfield

(b) Address 3718 E. 10 St K.C. Mo.

17. (a) Removal (b) Date thereof 2-26-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland Park, K.C. Mo

18. (a) Signature of funeral director Geo. H. Long

(b) Address 703 N. 10 St. K.C. Kansas

19. (a) 2-26-45 (b) D. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23  
year 1945 hour 2 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from Feb. 17 1945 to Feb 23 1945  
that I last saw h. E.R. alive on Feb 23 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac failure

Due to Rheumatic fever. Acute

Due to Otitis media

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 582

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)

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 2

23. Signature D. W. Richard (M. D. or other) DO.

Address 9506 Van Horn Rd. K.C. Mo. Date signed 3/27/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Coyle - Boyd - Murray

**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 Louis A. Long  
Licensed Embalmer No. 34107  
P. O. Address 203 N 10th St. C. Kan

**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.**