V. S. No. 2
00M—5-43
Rev. 5-17-39
1 X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 10 1945

Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 8531

Registrar's No. 976

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:
2822 East 9th. Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community About 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1100 Agnes Avenue 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Breckenridge Coughlin

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased 12-23 (Month) (Day) 1868 (Year)

8. AGE: Years 76 Months 2 Days 4 If less than one day ..... hr. ..... min.

9. Birthplace Lafayette County (City, town, or county) Missouri 1 (State or foreign country)

10. Usual occupation Plumber and Steamfitter

11. Industry or business

FATHER
12. Name Jerry Coughlin
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Catherine Foley
15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant Miss Mary Hagen
(b) Address 1100 Agnes Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-2-45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Mary's Cemetery

18. (a) Signature of funeral director J. F. O'Donnell Co.
(b) Address 3256 Broadway

19. (a) 3-1-45 (Date received local registrar) (b) T E Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27
year 1945 hour ..... minute ..... P. M.

21. I hereby certify that I attended the deceased from 8/1 - , 1944 to 2/28 , 1945
that I last saw him alive on 2/28 , 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Impaction of Ascending Colon

Due to Fractured R hip

Due to about

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 186.a 18

Of autopsy

Duration 3 days

5

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) accident

(b) Date of occurrence 8-1-44

(c) Where did injury occur? K. C. Jackson, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home (Specify type of place)

While at work? no (e) Means of injury fall

23. Signature D R Russell (M. D. or other)

Address 3231 E 11 St. Date signed 3/1/45

(Licensed Embalmer's Statement on Reverse Side)

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 Park G. Rowe

Licensed Embalmer No. 2347

P.O. Address K C 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.