

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8981

State File No. _____

FILED APR 8 1947

1425

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
(Specify whether
In this community 28 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. 408 W. 12 Terr.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SPENNER Elton Coghill

3. (b) If veteran, name war WORLD WAR I
3. (c) Social Security No. 487-10-7398

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife MRS. EDNA S. COGHILL
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased JUNE 24 1887
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 2
If less than one day hr. _____ min. _____

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

10. Usual occupation FIREMAN

11. Industry or business LOOSE WILES BISCUIT COMPANY

12. Name JAMES COGHILL

13. Birthplace BURBIN KENTUCKY
(City, town, or county) (State or foreign country)

14. Maiden name JANE THORPE

15. Birthplace BURBIN KENTUCKY
(City, town, or county) (State or foreign country)

16. (a) Informant MRS. EDNA S. COGHILL

(b) Address 408 WEST 12TH STREET TERRACE

17. (a) BURIAL (b) Date thereof MARCH 28 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 3-27-47 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1947 hour 2 minute A. M.

21. I hereby certify that I attended the deceased from March 7 1947 to March 26 1947, that I last saw him alive on March 26 1947, and that death occurred on the date and hour stated above.

Immediate cause of death
Subdiaphragmatic abscess-Post operative cholecystectomy Acute dilatation of heart
Due to Pulmonary edema and congestion

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

Major findings: Of operations _____
Of autopsy See above
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 W. W. Hart (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 3-26-47

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

MOTHER FATHER

MAY 23 1947

Dr. H...

STATEMENT BY LICENSED EMBALMER

33

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 *Bernard L. Horan*
Licensed Embalmer No. *4250*
P. O. Address *ACMO*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Wings
State File No. 8981
Registrar's No. 1425

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 1 years, months or days

3. (a) PRINT FULL NAME Elton Coghill
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex _____ 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 _____
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

19. (a) 3-27-47 (Date received local registrar) Sheldine Holm (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 26 year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: subdiaphragmatic abscess - post operative

Due to cholecystectomy - chronic cholecystitis (no stones)

Due to acute dilatation of heart

Other conditions pulmonary edema & congestion
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy see above
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 _____

Signature _____ (M. D. or other) _____
Date signed _____

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

SUPPLEMENTARY
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

1954

1955

1956