

FILED APR 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12905

State File No. \_\_\_\_\_

1233

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (in this place) <b>7 yrs.</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>406 West 17th Street</b>		d. STREET ADDRESS (If rural, give location) <b>406 West 17th Street</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Etta</b>		b. (Middle) <b>May</b>	
		c. (Last) <b>COXON</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>April 12, 1950</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4-1-75</b>
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Memory, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>John T. Costellow</b>		13b. MOTHER'S MAIDEN NAME <b>Matilda Jane Campbell</b>	
14. NAME OF HUSBAND OR WIFE <b>Alvin A. Coxon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Pearl Bonnot</b>		ADDRESS <b>406 W. 17th, K.C., Mo.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>History of Infections</b>	
INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>No Post Mortem</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>Natural</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Hugh H. Owens</b> (Degree or title) <b>Coroner</b>		23b. ADDRESS <b>1034 Realto Bldg</b>	
23c. DATE SIGNED <b>4-13-50</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>4-14-50</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Villisca, Iowa</b>	
DATE REC'D BY LOCAL REG. <b>4-14-50</b>		REGISTRAR'S SIGNATURE <b>Sheldine Holmes</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Melody-McGilley-Eylar</b>		ADDRESS <b>Kansas City, Mo.</b>	

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

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.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

Licensed Embalmer No. ....

P. O. Address.....

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.