

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **1252**  
**424**

FILED FEB 11 1954

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

1. PLACE OF DEATH a. COUNTY <p align="center"><b>Jackson</b></p>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <p align="center"><b>Missouri</b></p> b. COUNTY <p align="center"><b>Jackson</b></p>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <p align="center"><b>Kansas City</b></p>	c. LENGTH OF STAY (in this place) <p align="center"><b>32 yrs.</b></p>	c. CITY OR TOWN <p align="center"><b>Kansas City</b></p>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <p align="center"><b>6226 Forest</b></p>		e. STREET ADDRESS (If rural, give location) <p align="center"><b>6226 Forest</b></p>	

3. NAME OF DECEASED (Type or Print) a. (First) <p align="center"><b>RAY</b></p>	b. (Middle) <p align="center"><b>CLEGGETT</b></p>	c. (Last) <p align="center"><b>COFFEY</b></p>	4. DATE OF DEATH (Month) (Day) (Year) <p align="center"><b>Jan. 26, 1954</b></p>			
5. SEX <p align="center"><b>Male</b></p>	6. COLOR OR RACE <p align="center"><b>White</b></p>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <p align="center"><b>Married</b></p>	8. DATE OF BIRTH <p align="center"><b>Feb. 5, 1887</b></p>	9. AGE (in years last birthday) <p align="center"><b>66</b></p>	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) <p align="center"><b>Retired Clerk</b></p>		10b. KIND OF BUSINESS OR INDUSTRY <p align="center"><b>Post Office</b></p>		11. BIRTHPLACE (City and State or Foreign Country) <p align="center"><b>Ogallah, Kansas /</b></p>		12. CITIZEN OF WHAT COUNTRY? <p align="center"><b>USA</b></p>

13a. FATHER'S NAME <p align="center"><b>Seymour Coffey</b></p>	13b. MOTHER'S MAIDEN NAME <p align="center"><b>Zella Ridgeway</b></p>	14. NAME OF HUSBAND OR WIFE <p align="center"><b>Nina E. Coffey</b></p>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <p align="center"><b>no</b></p>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <p align="center"><b>none</b></p>	17. INFORMANT'S SIGNATURE OR NAME <p align="center"><b>Mrs. Nina E. Coffey, 6226 Forest, K.C. MO.</b></p>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary and rheumatic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <b>myocardial infarction</b>	DUE TO (c) <b>rheumatic acute stenosis with arr. fibrillation</b>	6 years with
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			410X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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) (Min.)	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 Apr, 1953, to Jan 26, 1954, that I last saw the deceased alive on Jan 22, 1954, and that death occurred at 5:30 P m., from the causes and on the date stated above.

23a. SIGNATURE <p align="center"><b>Harry C. Wall</b></p>	(Degree or title) <p align="center"><b>MD 420 Professional Reg</b></p>	23b. ADDRESS <p align="center"><b>1/27/54</b></p>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <p align="center"><b>Removal</b></p>	24b. DATE <p align="center"><b>1-29-54</b></p>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) <p align="center"><b>Kidder, Missouri</b></p>
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DATE REC'D BY LOCAL REG. <p align="center"><b>1-27-54</b></p>	REGISTRAR'S SIGNATURE <p align="center"><b>Sheraldine Smith</b></p>	25. FUNERAL DIRECTOR'S SIGNATURE <p align="center"><b>STINE &amp; McCLURE UND. CO.</b></p>	ADDRESS <p align="center"><b>K.C. MO.</b></p>
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr. Harry G. Wall  
Professional Bldg.  
Vi 4075

708 5:30

In at 11:30 until 3:30

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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.....  
Signature of Student Embalmer

Signed *F. S. Walter*.....

Licensed Embalmer No. *224*.....

P. O. Address *H. C.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.