

FILED AUG 8 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23655**  
**3166**

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>3166</u>	
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>2 da</u>		c. CITY OR TOWN <u>Carrollton</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>508 W Boston</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dorothy</u> b. (Middle) <u>Belle</u> c. (Last) <u>COFFEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 20-1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept-30-1921</u>		9. AGE (in years last birthday) <u>34</u>	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) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Carrollton Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Charles Sodgwick</u>		13b. MOTHER'S MAIDEN NAME <u>Myrtle White</u>		14. NAME OF HUSBAND OR WIFE <u>J.D. Coffey 508 W Boston Carrollton Mo</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>#70160551</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>V. D. Coffey 508 W. Boston Carrollton Mo</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cardiac + Respiratory failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral Embolism</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4201</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) _____		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 <u>2-1</u> , 19 <u>56</u> , to <u>July 20, 1956</u> , that I last saw the deceased alive on <u>7-20</u> , 19 <u>56</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>V. D. Coffey</u> (Degree or title) <u>D.O.</u>				23b. ADDRESS <u>494 Sloop Parkway</u>		23c. DATE SIGNED <u>7/20/56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 20, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Carrollton, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>7-21-56</u>		REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>STINE &amp; McCLURE UND. CO., 3235 Gillham Plaza</u>			

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

AUG 8  
1960

VS  
SEP 14 1960

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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 *Gerald A. Burger*.....

Licensed Embalmer No. *4763*.....

P. O. Address *Kansas City*.....

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.