

Health, welfare, public service
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 MEDICAL CERTIFICATION
 Frank B. Leitz
 All diseases in Part I must be causally related.

FILED AUG 15 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24465
 STATE FILE NUMBER
 Registrar's No. 3526

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Kansas City TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital			Length of stay in lb 27 yrs		STREET ADDRESS 5900 Ward Parkway		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EVAN Middle P. Last COFFEY				4. DATE OF DEATH Month July Day 25th Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1887		9. AGE (In years last birthday) 70	F UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer's Agent			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Hopkinsville, Ky.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Robert Coffey			13b. MOTHER'S MAIDEN NAME Ameretta Chalkley			14. NAME OF HUSBAND OR WIFE Elizabeth Coffey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Elizabeth Coffey, Kansas City, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. = Lt Hemiplegia - Probable Thrombus							INTERVAL BETWEEN ONSET AND DEATH 1 week		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Hypertension C.V. disease & decompensation						5+ years	
		DUE TO (c) plus acc. Auricular Fibrillation						5+ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from Apr. 22, 1952 to 7-25-57 and last saw her alive on July 25 1957 Death occurred at 5 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Frank B. Leitz M.D. (Degree or title)				22b. ADDRESS 1530 Irving St. Kansas City, Mo.		22c. DATE SIGNED 7-26-57			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE July 27, '57	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) Lexington, Missouri			
24. FUNERAL DIRECTOR FREEMAN MORTUARY, Kansas City, Mo.				25. DATE RECD. BY LOCAL REG. 7-27-57		26. REGISTRAR'S SIGNATURE Neva Minshall			

AUG 15 1957

9:45 A.M.

Francis Elmer

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 Clayton K Barnes

Licensed Embalmer No. 4793
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.