

FILED DEC 11 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5518

S. 300
r. 1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. _____ b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>478 Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>			Length of stay in 1b <u>16 YEARS</u>		d. STREET ADDRESS <u>416 W. 35th Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Marie</u> Last <u>Coad</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>57</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-95</u>		9. AGE (In years last birthday) <u>62</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>ASSISTANT MANAGER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MARTINIQUE APTS.</u>		11. BIRTHPLACE (City and state or country) <u>BENDENA, KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>ALBERT BUTLER DICKENS</u>			13b. MOTHER'S MAIDEN NAME <u>MAMIE E. OTTEN</u>			14. NAME OF HUSBAND OR WIFE <u>GEORGE F. COAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>514-05-9630</u>		17. INFORMANT <u>MRS. MILDRED CROUCH</u>			Address <u>416 WEST 35TH STREET KANSAS CITY, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Bronchiectasis and purulent bronchitis</u> DUE TO (c) <u>Emphysema + Pulmonary fibrosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5020</u>		
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 checked="" type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. _____			20d. INJURY OCCURRED WHILE AT <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 _____, to _____ and last saw her alive on _____ Death occurred at <u>9:57 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>H.L. Dwyer</u> (Degree or title) <u>md</u>					22b. ADDRESS <u>City Hall KC Mo</u>		22c. DATE SIGNED <u>11-22-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE <u>Nov. 22, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEWCOMER'S SONS</u>		23d. LOCATION (City, town, or county) <u>KANSAS CITY</u>		(State) <u>MISSOURI</u>		
24. FUNERAL DIRECTOR <u>D.W. NEWCOMER'S SONS</u>			ADDRESS <u>1331 - BROADWAY KANSAS CITY, MO</u>		25. DATE RECD. BY LOCAL REG. <u>11-22-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>		

MEDICAL CERTIFICATION

H. L. Dwyer

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 *Chester K Brown*

Licensed Embalmer No. *4921*

P. O. Address *KP 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.