

FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005423

STATE FILE NUMBER 716

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

300
-57

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 TOWN Gen'l Hosp. #1		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen'l Hosp. #1		d. STREET ADDRESS 104 W. 9	
3. NAME OF DECEASED (Type or print) John Coffey		4. DATE OF DEATH Month 2 Day 10 Year 1958	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH -1-14-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St James Mo
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unk		16. SOCIAL SECURITY NO. unk	17. INFORMANT B.E. Weichert Address 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) Cerebrovascular accident DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 1/2
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 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 Aug. 10, 1957 to Feb. 10, 1958 and last saw ^{him} alive on Feb. 10, 1958 Death occurred at 6:28 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) B. Burns, M.D.		22b. ADDRESS 24th & Cherry	22c. DATE SIGNED 2-10-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Anatomical	23b. DATE 2-12-58	23c. NAME OF CEMETERY OR CREMATORY Western Dental	23d. LOCATION (City, town, or county) (State) K.C. Mo
24. FUNERAL DIRECTOR B.E. Weichert ADDRESS K.C. Mo		25. DATE RECD. BY LOCAL REG. 2-11-58	26. REGISTRAR'S SIGNATURE neva minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

B. I. Burns



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 *B. E. Willett*

Licensed Embalmer No. *4075*
P. O. Address *708 No*

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.