

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029150

STATE FILE NUMBER

FILED SEP 5 1958

Registration, District No. 149 Primary Registration District No. 1002 Registrar's No. 3942

300
1-57

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 Kansas City		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"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 435 N. Drury		Length of stay in lb 75 Years	d. STREET ADDRESS (If outside, give location) 435 N. Drury Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Koons			4. DATE OF DEATH Month Day Year August 16th, 1958		
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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 June 21 1874	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Letrope Penn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Daniel Koons	13b. MOTHER'S MAIDEN NAME ? Johnson	14. NAME OF HUSBAND OR WIFE Mrs. Flora Koons
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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 Mrs. Charles H. Koons 435 N. Drury K.C., Mo. Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 43-00
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis	
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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>[Signature]</i> (Degree or title) 3	22b. ADDRESS 6627 Park St. Kansas City, Mo.	22c. DATE SIGNED 8-16-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-19-1958	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City, Mo.	ADDRESS	25. DATE RECD. BY LOCAL REG. 8-16-58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

Geo. C. Keelhofer USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

All diseases in Part I must be causally related.



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 *Harold D. Reich*

Licensed Embalmer No. *4998*
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.