

Health,  
& Welfare  
Public  
Service

300  
1-57

All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032595  
STATE FILE NUMBER  
4600

FILED OCT 15 1958 Registration District No. 149 Primary Registration District No. 1007 Registrar's No.

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4539 CHESTNUT AVE</b>		Length of stay in lb <b>35 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>4539 CHESTNUT AVE</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDWARD</b> Last <b>COLEMAN</b>			4. DATE OF DEATH Month <b>SEPT</b> Day <b>29</b> Year <b>1958</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT-16-1894</b>	9. AGE (In years last birthday) <b>64</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SIGN PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL OUTDOOR ADV. CO</b>	11. BIRTHPLACE (City and state or country) <b>MEMPHIS, TENNESSEE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>ROBERT COLEMAN</b>		13b. MOTHER'S MAIDEN NAME <b>SARAH GARRETT</b>		14. NAME OF HUSBAND OR WIFE <b>MRS. RUTH COLEMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES WORLD WAR I</b>		16. SOCIAL SECURITY NO. <b>496-03-5912</b>	17. INFORMANT <b>MRS. RUTH COLEMAN</b> Address <b>4539 CHESTNUT AVE. KANSAS CITY, MO.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Coronary insufficiency - severe</b>					<b>3 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <b>arterio sclerotic heart disease</b>					<b>? yrs</b>
DUE TO (c) _____					<b>if 200</b>
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 _____ 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 <b>March 1958</b> to <b>Sept 1958</b> and last saw her/him alive on <b>Sept 28 1958</b> Death occurred at <b>6:25 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>R. Paul Wright M.D.</b>			22b. ADDRESS <b>1324. Prof. Bldg</b>		22c. DATE SIGNED <b>Sept 29 58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Oct. 1. 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL PARK CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER &amp; SONS</b>		ADDRESS <b>1331. BROWN CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>9-30-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

R. Paul Wright



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. *4931*  
P. O. Address *KE-116*

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.