

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044217

STATE FILE NUMBER

FILED JAN 14 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6123

300  
-574

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> 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>KANSAS CITY</u> <u>7000</u> Inside Lights Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4001 WARKWICK BLDG. PLAZA NURSING HOME</u>		Length of stay in lb <u>4 YRS.</u>	d. STREET ADDRESS (If outside, give location) <u>11416 EAST 30TH STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle Last <u>KOONS</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>25</u> Year <u>1958</u>
5. SEX <u>1</u> <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>MARCH 24 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>74</u> F UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (City and state or country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>BAUMERT</u>		13b. MOTHER'S MAIDEN NAME <u>MAGGIE DECK</u>	14. NAME OF HUSBAND OR WIFE <u>CLAIR B. KOONS</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>NONE</u>	17. INFORMANT <u>MIS FERN KOONS</u> Address <u>3232 PENNSYLVANIA AVE. KANSAS CITY MISSOURI</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>Hemorrhage, gastric,</u> <u>Gastritis, Chronic</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterial hypertension.</u> DUE TO (c) <u>10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>45 MIN</u> <u>6 MO.</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>54</u>			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 <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 <u>3/2/53</u> to <u>12/25/58</u> and last saw her <sup>her</sup> alive on <u>12/19/58</u> . Death occurred at <u>6:45 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>James Q. Chambers M.D.</u> (Degree or title)		22b. ADDRESS <u>4620 Nichols Parkway</u>	22c. DATE SIGNED <u>12/25/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>DEC. 27 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEE'S SUMMIT CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>LEE'S SUMMIT MISSOURI</u>
24. FUNERAL DIRECTOR <u>DINNEWCOMER'S SONS</u>		ADDRESS <u>1331 BRUSH CREEK KANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-58</u>
26. REGISTRAR'S SIGNATURE <u>newman</u>			

All diseases in Part I must be causally related.

James Q. Chambers USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE MEDICAL CERTIFICATION

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 *Basil V. Honey* .....

Licensed Embalmer No. *47241* .....

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.