

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009330

Health, Welfare, Public Service

STATE FILE NUMBER 1174

FILED MAR 19 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1174

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>Bates</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Butler</b> <b>00710</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Research Hospital</b>		Length of stay in lb <b>30 days</b>	d. STREET ADDRESS (If outside, give location) <b>506 W. Ohio</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Alvie</b> Middle <b>C.</b> Last <b>Coberly</b>			4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1959</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>11-10-1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <b>77 5/7</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>Bates co. mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13a. FATHER'S NAME <b>Chandler Coberly</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Etta Hunter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no.</b>		16. SOCIAL SECURITY NO. <b>486-05-9716E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Azotemia - Renal insufficiency</b>		17. INFORMANT <b>Flora Coberly</b> Address <b>Butler mo.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Subacute Diffuse Vascular Nephritis - 3 mos.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
DUE TO (c) <b>Gonorrheal Arteritis - 3 mos.</b>		3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Vascular Hypertension - 446 X</b>		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 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, etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____
21. I attended the deceased from <b>2-21-59</b> , to <b>3-4-59</b> and last saw <sup>him</sup> alive on <b>3-3-1959</b> Death occurred at <b>7:00 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Graham Asher M.D.</b>		22b. ADDRESS <b>1220 Prof. Bldg. Kansas City 6-mo.</b>	
22c. DATE SIGNED <b>3-4-1959</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Mar. 4, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>-</b>	
23d. LOCATION (City, town, or county) <b>Butler, Missouri</b>		(State) _____	
24. FUNERAL DIRECTOR <b>Stine &amp; McClure</b> ADDRESS <b>Kansas City, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>3-4-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Graham Asher

MA. 1 2 1959

11-2-8180



NOV 10 1959

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 *Thomas A. Hoeller* .....

Licensed Embalmer No. *4995* .....

P. O. Address *B. C. ... Md.* .....

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.