

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017664

STATE FILE NUMBER

2423

JUN 9 1959

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 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 Gen. Hospital		Length of stay in lb 40 yrs	d. STREET ADDRESS (If outside, give location) 2902 E. 12th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First May Middle M. Last Coon			4. DATE OF DEATH Month 5- Day 14 Year 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 31 1875	9. AGE (In years last birthday) 84 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and state or country) KANSAS Louisiana		12. CITIZEN OF WHAT COUNTRY? U. S. A
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE Clarence R. Coon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, or unknown) (If yes give war or dates of service) NO <input checked="" type="checkbox"/> X <input checked="" type="checkbox"/> X		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mrs. May Edwards 4748 Douglas, KCK Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 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.) 491X		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 5-12-59 to 5-14-59 and last saw her alive alive on 5-14-59 Death occurred at 9:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Alexander G. Gelperin</i> (Degree or title) D			22b. ADDRESS General Hospital		22c. DATE SIGNED 5-15-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-16-1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hills		23d. LOCATION (City, town, or county) (State) Kansas City Missouri.	
24. FUNERAL DIRECTOR Floral Hills Memorial Chapels, Inc ADDRESS			25. DATE RECD. BY LOCAL REG. 5-15-59	26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	

Abraham Gelperin 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 *Forest D. Caldwell*

Licensed Embalmer No. *4714*
P. O. Address *KCMO.*

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.