URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS ~~OCT 16~~ Sept. 28 1959

59-031738

STATE FILE NUMBER

Registration District No. 59 Primary Registration District No. _____ Registrar's No. 145

NDED

1. PLACE OF DEATH
a. COUNTY Cass
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Peculiar Twp. | Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Pleasant View Rest Home | Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Cass
c. CITY OR TOWN Harrisonville | Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Pleasant View Rest Home | Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Charles Middle: Last: Cooley
4. DATE OF DEATH Month, Day, Year: September 12, 1959
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: April 25, 1875
9. AGE (last birthday): 84
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HR: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Louisville, Ky.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Judson Cooley
13b. MOTHER'S MAIDEN NAME: Nancy ?
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Pleasant View Rest Home Records Address: Harrisonville, Mo.

MEDICAL CERTIFICATION

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)	Coronary Occulsion	2 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cardio-renal disease	5 yrs.
DUE TO (c)	Arteriosclerosis	10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 1955, to Sept.12,1959 and last saw her/him alive on Sept.12,1959
Death occurred at 11:30 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H. E. Finch (Degree or title) MD
22b. ADDRESS Harrisonville Mo
22c. DATE SIGNED Sept 12, 1959

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Sept.14,1959
23c. NAME OF CEMETERY OR CREMATORY: University of Missouri School of Anatomy
23d. LOCATION (City, town, or county) (State): Columbia, Mo.

24. FUNERAL DIRECTOR: Runnenburger's ADDRESS: Harrisonville, Mo.
25. DATE RECD. BY LOCAL REG.: Sept 12-1959
26. REGISTRAR'S SIGNATURE: Mrs Ray Sebree

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to cor
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.