

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036119

FILED VS NOV 2 1959

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5004

ENDED

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		Length of stay in 1b 70 Yrs		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 Little Sisters of Poor			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3810 FLORA		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE Elizabeth COAN				4. DATE OF DEATH Month Day Year October 16 1959									
5. SEX Female		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1877		9. AGE (last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Springfield MA MO		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13a. FATHER'S NAME No Record			13b. MOTHER'S MAIDEN NAME No Record			14. NAME OF HUSBAND OR WIFE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Elizabeth Fitz Gerald		Address 1507 E 39 ST						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia (hypostatic)										INTERVAL BETWEEN ONSET AND DEATH 4 days			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerosis										10 Yrs			
DUE TO (c) Carcinoma of Stomach										6 mos			
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
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.		Month, Day, Year											
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 bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from 3/19/58 , to 10/16/59 and last saw her 10/15/59 alive on Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE Cosetta A. Fogarty				22b. ADDRESS 402 Northman Bldg No 10				22c. DATE SIGNED 10/16/59					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)					
Burial		Oct 19 1959		St Mary's Cemetery		KANSAS CITY MO		MO					
24. FUNERAL DIRECTOR Sheil Funeral Home K.C. Mo.				25. DATE RECD. BY LOCAL REG. 10-17-59		26. REGISTRAR'S SIGNATURE new Marshall							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Cosetta A. Fogarty

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 Richard E. Carroll

Licensed Embalmer No. 4829

P. O. Address R.C.S.W.

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.