

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036506

FILED VS OCT 28 1959

Registration District No. 46 Primary Registration District No. 3026 Registrar's No. 461

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Johnson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 3 days	c. CITY OR TOWN Holden Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Madison Twp. Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First BERTHA Middle COY Last			4. DATE OF DEATH Month October Day 19 Year 1959	
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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 4-4-1870	9. AGE (last birthday) 89	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY USA.
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13a. FATHER'S NAME Ernest Fredrick Wolf	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Ambrose E. Coy
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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 Address Mrs. Glen Simmermon, Holden, Mo.
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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) Pulmonary Congestion		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Massive Cerebral Infarction		
DUE TO (c) Right Carotid Artery Thrombosis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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 checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at **1 pm** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James G. Bridgers M.D.	22b. ADDRESS 1509 W. Truman Rd. Independence, Mo.	22c. DATE SIGNED 10-22-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 10-22-1959	23c. NAME OF CEMETERY OR CREMATORY Holden Cemetery	23d. LOCATION (City, town, or county) Holden, Mo.
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24. FUNERAL DIRECTOR ADDRESS E B CAST HOLDEN MO	25. DATE RECD. BY LOCAL REG. 10-20-59	26. REGISTRAR'S SIGNATURE James G. Bridgers
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

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 _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4059

P. O. Address Holden, Va

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.