JRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–040204
STATE FILE NUMBER

FILED VS NOV 3 0 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5454

ENDED

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Length of stay in 1b: 30 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 313 E. 70th TERR — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE missouri b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 313 E 70th TERR — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First / Middle / Last: WILLIAM ARTHUR McCOY
4. DATE OF DEATH Month / Day / Year: NOV 10, 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: MAY 28, 1883
9. AGE (last birthday): 76 yrs. — 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): RETIRED MANAGER EMERY BIRD
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): STANBERRY MO.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: SAMUEL D. Mc COY
13b. MOTHER'S MAIDEN NAME: WILLIE A. MILLIGAN
14. NAME OF HUSBAND OR WIFE: GRETCHIN B. McCOY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 486 09 8556
17. INFORMANT: GRETCHIN McCOY — Address: 313 E 70th TERR

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 4 5 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) CORONARY A S
DUE TO (c) GENERALIZED A S INCLUDING CEREBRAL C V A — YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CARCINOMA LEFT LUNG
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 MAY 18, 1959, to NOV 10, 1959 and last saw her/him alive on NOV 10, 1959
Death occurred at 5.50 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William R Brown MD. (Degree or title)
22b. ADDRESS 751 E. 63rd K.C. 10, Mo.
22c. DATE SIGNED Nov 11/59

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV 12, 1959
23c. NAME OF CEMETERY OR CREMATORY: MT. MORIAH CEM
23d. LOCATION (City, town, or county) (State): KANSAS CITY MO.
24. FUNERAL DIRECTOR / ADDRESS: D. W. NEWCOMER'S SONS K.C. MO.
25. DATE RECD. BY LOCAL REG.: 11-12-59
26. REGISTRAR'S SIGNATURE: Neva Minabell

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF William R. Brown

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 Chester K Brown

Signature of Student Embalmer

Licensed Embalmer No. 192

P. O. Address KP 1MD

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