

**MURKIN DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

'59 043676

FILED VS JAN - 6 1960

STATE FILE NUMBER

MEMORANDUM

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 2

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Clay</u>					
b. CITY (If outside corporate limits, give TOWN OR TOWN) <u>No. Kansas City</u>		Length of stay in lb <u>40 years</u>		c. CITY OR TOWN <u>North Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1031 E. 23rd. ave</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1031 E. 23rd. ave</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Minnie Susan</u> Middle <u>Koonce</u> Last <u>Koonce</u>				4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1959</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>8-7-1884</u>	9. AGE (last birthday) <u>75</u>	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) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Montgomery Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Isaac Painter</u>			13b. MOTHER'S MAIDEN NAME <u>Nancy Ellen Painter</u>			14. NAME OF HUSBAND OR WIFE <u>Thomas E. Koonce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Georgia Todd, 1031 E. 23rd. ave</u>			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) <u>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Arterio Sclerotic Heart Disease</u>							
DUE TO (c)									
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 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>D. Pate M.D. (Coroner)</u>				22b. ADDRESS <u>North Kansas City Mo.</u>				22c. DATE SIGNED <u>12/31/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>Jan. 1, 60</u>	<u>East Slope Cem.</u>			<u>Riverside Mo</u>			
24. FUNERAL DIRECTOR <u>D.W. Newcomer, M.D.C.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>1-1-60</u>	26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>			

(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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John V. Henrick, Jr.

Licensed Embalmer No. 4848

P. O. Address S. C. 17, Mo

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.