

FEDERAL BUREAU OF INVESTIGATION
FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 19 1960

STATE FILE NUMBER
6167-59-046727

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6167

RECEIVED

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY SALINE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 2 days	c. CITY OR TOWN MALTA BEND BOX 18 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital, K.C., Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First WILBER Middle NONE Last COATS			4. DATE OF DEATH Month December Day 21 Year 1959		
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5. SEX MALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-26-93	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) BLACKWATER, MO	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME RALPH COATS	13b. MOTHER'S MAIDEN NAME MARY SHIELDS	14. NAME OF HUSBAND OR WIFE -
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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) YES WW II	16. SOCIAL SECURITY NO. -	17. INFORMANT OFFICIAL RECORDS VA HOSPITAL, K.C., MO.	Address
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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) Encephalomalacia, right cerebral hemisphere		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Thrombosis of right internal carotid artery	
	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
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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.)
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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 checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION VA	COUNTY Saline	STATE Mo.
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21. I attended the deceased from Dec 19, 1959 to Dec 21, 1959 and last saw him/her alive on Dec 21, 1959 Death occurred at 8:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) ALBERT L. CHASSON, M.D.	22b. ADDRESS VA Hospital, Kansas City, Mo.	22c. DATE SIGNED 12-22-59
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Dec 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Malta Bend Cemetery	23d. LOCATION (City, town, or county) (State) Saline Co. Mo.
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24. FUNERAL DIRECTOR Ernest H. Green	ADDRESS Thresholt Mo	25. DATE RECD. BY LOCAL REG. 12-23-59	26. REGISTRAR'S SIGNATURE Neve Marshall
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

0861 1 B

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 Georgette Green
Licensed Embalmer No. 4220

P. O. Address Marshall

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