

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001461

FILED VS. FEB 1 1960 149

Primary Registration District No. 1002 Registrar's No.

226 STATE FILE NUMBER

| | | | | | | | | | |
|---|---|---|---|--|--|--|--|------------------------------------|------|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 9 days | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA Hospital | | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 214 Troup, | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Sherman Middle L. Last Coffee | | | | 4. DATE OF DEATH Month 1st. Day 11th Year 1960 | | | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 6-14-07 | 9. AGE (last birthday) 52 yrs | IF UNDER 1 YEAR Months | IF UNDER 24 HR Days | Hours | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (City and state or country) Bigelow, Kansas | | 12. CITIZEN OF WHAT COUNTRY U.S. | | | |
| 13a. FATHER'S NAME Sherman Coffee | | | 13b. MOTHER'S MAIDEN NAME Mary Bigelow | | | 14. NAME OF HUSBAND OR WIFE Iantha Coffee | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 9/14/43 to 2/15/46 | | | 16. SOCIAL SECURITY NO. 495100480 | | 17. INFORMANT Address Iantha Coffee, 214 Troup, K.C., Kansas | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion and edema DUE TO (b) Cardiac hypertrophy and dilatation DUE TO (c) Arteriolar nephrosclerosis with hypertension 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 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 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 January 2, 1960 to January 11, 1960 Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE S. A. Turner (Degree or title) S. A. Turner, M.D. | | | | 22b. ADDRESS MD VA Hospital, Kansas City, Mo | | | | 22c. DATE SIGNED 1-12-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Reburied | | 23b. DATE 1-15-60 | 23c. NAME OF CEMETERY OR CREMATORY F.T. Hearen Wath | | | 23d. LOCATION (City, town, or county) (State) Hearen Wath, K.C. Kansas | | | |
| 24. FUNERAL DIRECTOR Bailey Funeral Home K.C. Kansas | | | | 25. DATE RECD. BY LOCAL REG. 1-14-60 | | 26. REGISTRAR'S SIGNATURE Shirley Marshall | | | |

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 _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4431

P. O. Address W. C. M.

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.