

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

**60-010870**

**FILED VS. MAR 23 1960 149**

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1377 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>38 YEARS</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5431 Forest</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Emilie</u> Middle <u>J.</u> Last <u>Coons</u>				4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>2-18-69</u>	9. AGE (last birthday) <u>91</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>KOENIGSBURG, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>CARL GRING</u>			13b. MOTHER'S MAIDEN NAME <u>WILHEMINA BEITER</u>			14. NAME OF HUSBAND OR WIFE <u>SAMUEL E. COONS</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 Address <u>MISS ELSIE COONS, 5431 FOREST</u>				
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>Pneumonia (Broncho-)</u> DUE TO (b) <u>Senility</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH		
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 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.)					
20c. TIME OF INJURY Hour <u>11:45</u> Month, Day, Year <u>2/26/60</u> a.m. p.m.		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 <u>11:45</u> to <u>2/26/60</u> and last saw her alive on <u>3/7/60</u> Death occurred at <u>11:45</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>[Signature]</u>				22b. ADDRESS <u>701 E 63 St.</u>			22c. DATE SIGNED <u>3/8/60</u>		
23a. BURIAL CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>MAR. 10, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BUCKLIN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>BUCKLIN, KANSAS</u>			(State)	
24. FUNERAL DIRECTOR <u>WUEHLEBACH</u> ADDRESS <u>6800 TROOST</u>				25. DATE RECD. BY LOCAL REG. <u>3-8-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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 J. T. Crowell

Licensed Embalmer No. 4904

P. O. Address K. 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.