

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-030695

FILED AUG 29 1960 179

Primary Registration District No. 1002 Registrar's No. 4135

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY JACKSON				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Length of stay in 1b 54 YEARS		c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 205 BRUSH CREEK BLVD.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First OLLIE Middle BROKAW Last MESSENGER				4. DATE OF DEATH Month AUGUST Day 9 Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH MAR 14 1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MULTIGRAPH OPERATOR			10b. KIND OF BUSINESS OR INDUSTRY LONG-BELLUMBER CO.		11. BIRTHPLACE (City and state or country) CANTON, ILLINOIS		12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME JOSEPH MESSENGER		13b. MOTHER'S MAIDEN NAME JOHANNA BROKAW			14. NAME OF HUSBAND OR WIFE ---		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 487-07-6158		17. INFORMANT PURCELL MESSENGER Address 6402 MONTGALL AVENUE KANSAS CITY, MISSOURI			
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>Hemorrhage deathis due to Bone marrow deterioration (Thio tests?)</u> DUE TO (b) <u>Fibrosarcoma of L. psoas muscle recurrent</u> DUE TO (c) <u>intestinal obstruction</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"/> N: <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <u>July 21 1960</u> to <u>Aug 4-60</u> and last saw her alive on <u>Aug 7-60</u> Death occurred at <u>11:35 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>R. R. Coffey M.D.</i> (Degree or title)			22b. ADDRESS <u>1111 1/2 1103 Grand</u>			22c. DATE SIGNED <u>8-10-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUGUST 11, 1960	23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY		23d. LOCATION (City, town, or county) KANSAS CITY MISSOURI			
24. FUNERAL DIRECTOR D. W. NEWCOMER'S SONS KANSAS CITY, MO.			25. DATE RECD. BY LOCAL REG. <u>8-11-60</u>	26. REGISTRAR'S SIGNATURE <i>H. L. Dwyer</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF R. R. Coffey

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 *R. C. Nelson*

Licensed Embalmer No. 442

P. O. Address R. C. Nelson

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.