

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 20 1960

-60-035116

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4592

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>15 months</u>	c. CITY OR TOWN <u>Raytown</u>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph's Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5924 Hedges</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Garnet</u> Middle <u>Irene</u> Last <u>Wilcoxson</u>			4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1960</u>	
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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>8-31-92</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	IF UNDER 24 HR Hours <u>5</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Sales lady</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>	11. BIRTHPLACE (City and state or country) <u>Wellington, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John L. Golladay</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Adams</u>	13c. NAME OF HUSBAND OR WIFE <u>N.T. Wilcoxson</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO. <u>493-34-1011</u>	17. INFORMANT <u>N.T. Wilcoxson Jr., Raytown, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudo tuberculosis enterocolitis</u>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <u>Carcinomatous</u>		
DUE TO (c) <u>Adeno Carcinoma Tail of Pancreas</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		

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 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.)
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20c. TIME OF INJURY Hour <u>5:50</u> a.m. <u>P.M.</u> Month, Day, Year <u>Jan 1960</u>	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 <u>Raytown, Mo.</u>	COUNTY <u>Mo.</u>	STATE <u>Mo.</u>
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21. I attended the deceased from <u>Jan 1960</u> to <u>Sept 5 1960</u> and last saw her alive on <u>Sept 5</u> Death occurred at <u>5:50 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>R R Coffey MD</u> (Degree or title)	22b. ADDRESS <u>1103 Grand</u>	22c. DATE SIGNED <u>9-6-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-8-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	23d. LOCATION (City, town, or county) <u>Lexington, Mo.</u>	23e. STATE <u>Mo.</u>
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24. FUNERAL DIRECTOR <u>Egypt Mortuary, Raytown, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-7-60</u>	26. REGISTRAR'S SIGNATURE <u>H. L. Sawyer</u>
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DOCUMENT

MEDICAL CERTIFICATION

R.R. Coffey

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 John R. Sed
Licensed Embalmer No. 453
P. O. Address Kansas

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