

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-038672

VS

OCT 25 1960

Registration District No. 154 Primary Registration District No. 5575 Registrar's No. 37

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Hill</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>1 yr.</b>		c. CITY OR TOWN <b>Itasca</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5905 E. 93 St.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>No street numbers</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>G.</b> Last <b>Coffin</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>14,</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1869</b>	9. AGE (last birthday) <b>90</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Arlington Tenn.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Horace Griffin</b>			13b. MOTHER'S MAIDEN NAME <b>Zylphia Thomas</b>			14. NAME OF HUSBAND OR WIFE <b>Richard W. Coffin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. R. M. Eldridge 800 W. 58 th. Terr.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute-myocardial decompensation</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Senility</b>							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 <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 checked="" 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 <b>9/9/57</b> to <b>10/9/60</b> and last saw her/him alive on <b>10/9/60</b> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>W. W. W. W.</b>				22b. ADDRESS <b>336 West 36th St. Kansas City, MO.</b>		22c. DATE SIGNED <b>10/14/60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/15/60</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Itasca Texas</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Stine &amp; McClure K. C. Mo.</b>			25. DATE RECD. BY LOCAL REG <b>10/20/60</b>		18. REGISTRAR'S SIGNATURE <b>Sterling Goddard</b>		

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. S. Walton

Licensed Embalmer No. 2744

P. O. Address R. C. M.

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.