

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001305

DEPARTMENT OF HEALTH AND WELFARE

FILED VS FEB 8 1961

149

Primary Registration District No. 1002

Registrar's No. 349

STATE FILE NUMBER

WRITE
STUB

AMENDED

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59

85

7

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TYPEWRITER RIBBON

DATE AMENDED
INSTEAD OF
SHOULD READ
ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

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) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>20 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6400 Indiana</u>	
3. NAME OF DECEASED (Type or print) First <u>JAUNITA</u> Middle <u>MAE</u> Last <u>COOPER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/31/1920</u>	
9. AGE (last birthday) <u>40</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beautician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Beauty Shop</u>		11. BIRTHPLACE (City and state or country) <u>Cheyenne Wyo.</u>	
13a. FATHER'S NAME <u>James N. Williams</u>				13b. MOTHER'S MAIDEN NAME <u>Letha Fleming</u>		14. NAME OF HUSBAND OR WIFE <u>James M. Cooper</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>James M. Cooper 13.C., Mo</u>		17. INFORMANT <u>James M. Cooper 13.C., Mo</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>Uremia</u> DUE TO (b) <u>Obstruction of both ureters</u> DUE TO (c) <u>Carcinoma of ureter</u> 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 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 <u>1-5-61</u> to <u>1-21-61</u> and last saw her/him alive on <u>1-21-61</u> 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) <u>R.R. Coffey M.D.</u>				22b. ADDRESS <u>K.C., Mo.</u>		22c. DATE SIGNED <u>1-21-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>1-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Sedalia, Mo.</u>	
24. FUNERAL DIRECTOR <u>C.H. Blackman & Son M.C., Mo</u>				25. DATE RECD. BY LOCAL REG. <u>1-21-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Bert B. Bennett

Licensed Embalmer No. 4656

P. O. Address H. C., Mo.

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.