

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

761-008698  
STATE FILE NUMBER

AMENDED

FILED APR 6 1961

Primary Registration District No. 1002 Registrar's No. 1434

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</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>309 W. 13th</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>309 W. 13th</b>

3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>ELMO</b> Last <b>COLLEY</b>			4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1961</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10-6-11</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Paramount Theater</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Ben Colley</b>	13b. MOTHER'S MAIDEN NAME <b>Beatrice Daniels</b>	14. NAME OF HUSBAND OR WIFE <b>Marie Lois Colley</b>
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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) <b>WW#2</b>	16. SOCIAL SECURITY NO. <b>WW#2</b>	17. INFORMANT Address <b>Marie L. Colley- 309 W. 13th. St.</b>
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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>Coronary thrombosis</b> DUE TO (b) <b>Acute coronary disease.</b> DUE TO (c) <b>Acute myocardial infarction.</b> 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 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Month, Day, Year
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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
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21. I attended the deceased from **12/2/51** to **2/9/60** and last saw **him** alive on **2/9/60**  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>M. C. Wofley, D.O.</i> (Degree or title)	22b. ADDRESS <b>336 West 36th Kansas City, Mo.</b>	22c. DATE SIGNED <b>3/21/61</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3-22-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill</b>	23d. LOCATION (City, town, or county) <b>Kansas City</b>	STATE <b>Mo.</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Melody-McGilley-Eylar 1800 E. Linwood</b>	25. DATE RECD. BY LOCAL REG. <b>3-21-61</b>	26. REGISTRAR'S SIGNATURE <i>Ruth B. Long</i>
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DATE AMENDED  
  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
  
 INSTEAD OF  
  
 DOCUMENT  
  
 MEDICAL CERTIFICATION  
  
 BY AFFIDAVIT OF **M. C. Wofley**  
  
 ITEM NO. SHOULD READ

Dr. W. C. Worle  
Hyde Park Hotel

VA 1-4292-

OK: 10-4

**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

*Steph J. Dickmore*

Licensed Embalmer No. 5120

P. O. Address K. C. 9, 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.