

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-61-008841**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 976

STATE FILE NUMBER

AMENDED

FILED VS MAR 13 1961

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 COBURN  
 SHOULD READ  
 ITEM NO.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Jackson</b>  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kansas City</b>  |  | Length of stay in 1b<br><b>2 Weeks</b>  | c. CITY OR TOWN <b>St. Joseph</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Research Hospital</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>708 Hall Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>EDWIN JOSEPH HEENEY</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>February 23, 1961</b>  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>       | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-13-1889</b>  | 9. AGE (last birthday)<br><b>76</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Severance, Kansas</b>  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>Ed Heeneey</b>  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Hampson</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Loretta Heeneey</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes World War I</b>  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |   | 17. INFORMANT<br><b>Mrs. Loretta Heeneey, St. Joseph, Mo.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Compression from acute subdural and extradural Hematoma, Post-operative</b><br>DUE TO (b) <b>Chronic Calcified Subdural Hematoma</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>? years</b>                  |
| 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.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour _____ a.m. _____ p.m.  |  | Month, Day, Year<br><b>3 3 3</b>  |   |  |  |
| 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 <b>Feb. 10, 1961</b> to <b>Feb 23, 1961</b> and last saw him alive on <b>Feb 23, 1961</b><br>Death occurred at <b>3:05 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |  |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Donald F. Coburn M.D.</b>   |  |   | 22b. ADDRESS<br><b>411 Nichols Road<br/>Kansas City 13, Mo.</b>   |  | 22c. DATE SIGNED<br><b>2-23-61</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 23b. DATE<br><b>Feb. 24, 1961</b>   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Joseph, Missouri</b>         |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Freeman Mortuary, Kansas City, Mo.</b>  |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>2-24-61</b>  | 26. REGISTRAR'S SIGNATURE<br><b>Ruth Long</b>  |  |

**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 Walter H. Erwin

Licensed Embalmer No. 4352

P. O. Address K. 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.