

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025365

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3550 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>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>14 yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Hearthstone Nursing Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3525 Paseo</b>
b. CITY OR TOWN <b>708 Garfield</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>A.</b> Last <b>Meek</b>	4. DATE OF DEATH Month <b>July</b> Day <b>16th</b> Year <b>1961</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>April 3, 1876</b>	9. AGE (last birthday) <b>85 yrs.</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>Homemaker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Shelbyville, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
---	---	--	---

13a. FATHER'S NAME <b>James O. Coffman</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Ann Albert</b>	14. NAME OF HUSBAND OR WIFE <b>Thomas A. Meek-Deceased</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 <b>Mrs. T. Pearl York, 3525 Paseo, K.C.Mo.</b>	Address
---	--	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>
IMMEDIATE CAUSE (a) <b>Coronary Occlusion</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)		

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 type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Ft. Scott, Kansas</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
--	--	--	--------------------------	--------------------------

21. I attended the deceased from <b>4-19-60</b> to <b>7-16-61</b> and last saw her <b>1:50 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	and last saw him alive on <b>7-16-61</b>
Death occurred at <b>1:50 p.m.</b>	

22a. SIGNATURE <b>Frank Paul Lawrence</b>	(Degree or title)	22b. ADDRESS <b>428 So White Ave</b>	22c. DATE SIGNED <b>7-16-61</b>
--	-------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>July 18, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery,</b>	23d. LOCATION (City, town, or county) (State) <b>Ft. Scott, Kansas</b>
---	-----------------------------------	--	---

24. FUNERAL DIRECTOR <b>Muehlebach Funeral Home, 6800 Troost Ave.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-17-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
--	---------	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

Frank Paul Lawrence

Dr. Frank Laurangera

**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 E. P. Nichols

Licensed Embalmer No. 4997

P. O. Address E. P. Nichols

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.