

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032209

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 393 Primary Registration District No. 1002 Registrar's No. 4835 STATE FILE NUMBER

FILED OCT 11 1961

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		Length of stay in 1b <u>25 yrs.</u>	c. CITY OR TOWN <u>Kansas City North, Missouri</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3836 N. Garfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>3836 N. Garfield</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>ELIZABETH</u> Last <u>COONS</u>	4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1961</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1895</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <u>Duluth, Minnesota</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Carl Rich</u>	13b. MOTHER'S MAIDEN NAME <u>Christine Prielle</u>	14. NAME OF HUSBAND OR WIFE <u>Henry A. Coons, Sr.</u>
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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) <u>No</u>	17. INFORMANT Address <u>Mo. Mrs. Homer D. Coons-3119 Russell Rd. K.C.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>		<u>20 min.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	<u>Years</u>
	DUE TO (c) <u>Arteriosclerosis</u>	<u>Years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>	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
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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 _____ a.m. _____ 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 <u>Oct-1959</u> to <u>Sept-21-1961</u> and last saw her/him alive on <u>Sept-21-1961</u> Death occurred at <u>9:30</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Richard Hill D.O.</u>	22b. ADDRESS <u>10 W. Kansas Liberty, Mo.</u>	22c. DATE SIGNED <u>9-29-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept. 30, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Slope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Riverside, Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>D.W. Newcomer's Sons-North Kansas City, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-29-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF T. Hill

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 Blair H. Hill

Licensed Embalmer No. 4586

P. O. Address K.C. 18, 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.