

MISSOURI DIVISION OF PUBLIC HEALTH AND WELFARE

STANDARD CERTIFICATE OF DEATH

-62-006452

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1028 STATE FILE NUMBER

AMENDED

FILED MAR 7 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 50 Yrs	c. CITY OR TOWN Kansas City
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 910 Kensington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 910 Kensington

3. NAME OF DECEASED (Type or print) PEARL COFFEY			4. DATE OF DEATH Month February Day 19 Year 1962			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/23/1881	9. AGE (last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Sweetsprings Mo	11. BIRTHPLACE (City and state or country) MSA		12. CITIZEN OF WHAT COUNTRY MSA
13a. FATHER'S NAME Sims		13b. MOTHER'S MAIDEN NAME Ink		14. NAME OF HUSBAND OR WIFE Walter Coffey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Coffey 910 Kensington KC MO	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Artery thrombosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary Artery Arteriosclerosis

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.
 Yes No 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 _____ 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.) Kansas City Jackson Mo	20f. CITY, TOWN, OR LOCATION Kansas City Jackson Mo	COUNTY _____ STATE _____
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21. I attended the deceased from 2-17-62 to _____ and last saw her/him alive on 2-18-62
Death occurred at 2:20 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>J L Shireman, M.D.</i> (Degree or title)	22b. ADDRESS 4606 St John KC Mo	22c. DATE SIGNED 2-20-62
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/21/62	23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City Missouri
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24. FUNERAL DIRECTOR Sheil Funeral Home Kansas City Mo ADDRESS _____	25. DATE RECD. BY LOCAL REG. 2-20-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 Shireman
 SHOULD READ
 BY AFFIDAVIT OF

2651

201 5 100 778.1.1

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 *Thomas A. Skid* _____

Licensed Embalmer No. 4954 _____

P. O. Address *J.P.M.* _____

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.