MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

21448
2583

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City No. Lakeside Hosp. St. ..... Ward)
Registration District No. .....
Primary Registration District No. .....
File No. .....
Registered No. .....

2. FULL NAME: Lucille Coleman

(a) Residence. No. 3815 Paseo St., 13 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 6, 1889

7. AGE: Years 39 Months 6 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY): Mo.

PARENTS
10. NAME OF FATHER: Wm Elkhanna Coleman
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Ky.
12. MAIDEN NAME OF MOTHER: Elizabeth E. Wilson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY): Ohio

14. INFORMANT: Mrs. C. N. Andelotte
(Address): 3714 Paseo

15. FILED 6/8, 1929 M. M. Crowe asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 6 1929

17. I HEREBY CERTIFY, That I attended deceased from June 3/29, 19..., to June 6, 19..., that I last saw h... alive on June 6, 19..., and that death occurred, on the date stated above, at 10 45 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

55A
1292
Cardiac Collapse due to Acute Mitral Endocarditis 4 hrs.
127A
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Laparotomy. Choleperitonitis and Cholecystectomy 2
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? Yes. DATE OF June 4
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) Geo J Conley, M. D.
6/7, 1929 (Address) 810 Chambers Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Cremation
DATE OF BURIAL: June 10 1929

20. UNDERTAKER: D. M. Newomer's Sons
ADDRESS: K. C. Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

metroneuria