FEB 27 1934

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

Do not use this space.

1729

File No. .....

Registered No. 7

1. PLACE OF DEATH

County: Lafayette — Registration District No. 460

Township: Sedalia — Primary Registration District No. 5623

City: Higginsville (No. ..... St. ..... Ward)

2. FULL NAME: Richard W. Colborn

(a) Residence. No. Confederate Home St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: White

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): Nov 12 1845

7. AGE: Years 88 | Months 2 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Jackson Co
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: Rev S. B. Colborn

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Tennessee
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER: Elizabeth

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY)

14. INFORMANT: Martha Maison Inst Portland
(Address) Higginsville, Mo. Dec

15. FILED 1-17, 1934 Dr. W. A. Braeckleir
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): January 16 1934

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h. alive on Jan 16, 1934, and that death occurred, on the date stated above, at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
82 A
Instantly (duration) ..... yrs. — mos. ..... ds.

CONTRIBUTORY (SECONDARY): Hard Straight Stroke
Several Years ago (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) F. A. Howard, M. D
1-17-, 1934 (Address) Higginsville Mo

*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: Confederate Home

DATE OF BURIAL: 1/17 - 1934

20. UNDERTAKER: Astsodo Higginsville, Mo.

ADDRESS