V. S. No. 2
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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18214

State File No.

FILED MAY 18 1944

Registration District No. 1944

Primary Registration District No. 3026

Registrar's No. 98

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 407-S. Spring St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 40 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 407-S. Spring St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ——

3. (a) PRINT FULL NAME Katie Belle Colley
3. (b) If veteran, name war ——
3. (c) Social Security No. None

4. Sex Female
5. Color or race Negro
6. (a) Single, widowed, married, divorced ——
6. (b) Name of husband or wife Deceased Henry Colley
6. (c) Age of husband or wife if alive —— years
7. Birth date of deceased Sept. 8, 1858
(Month) (Day) (Year)

8. AGE: Years 85 yrs | Months 7 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Lafayette, Co., Mo.
(City, town or county) (State or foreign country)
10. Usual occupation None
11. Industry or business ——

FATHER
12. Name Aaron Mills
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Melvina Barnes
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Katherine Gossett
(b) Address 1016 E. 22nd St. K.C., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 19, '44
(Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem.
18. (a) Signature of funeral director C. E. Davis
(b) Address 312 E. Lexington Ind. P. Mo.
19. (a) 4-19-1944 (Date received local registrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th
year 44 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from April 8, 1944, to April 19, 1944
that I last saw h..... alive on April 15, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Influenza	7 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other)
Address 1195 Farmer Indep. Date signed 4-19-44

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Registered Apprentice No. .....,

working under my personal supervision.

Signed L. G. Harris Sr

Licensed Embalmer No. 5388

P. O. Address TC 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 this body is not embalmed, fact should be so stated above.