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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1946
Registration District No. 172

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 45

Primary Registration District No. 3034

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

1. PLACE OF DEATH:
(a) County Lafayette
(b) City or town Higginsville, Mo.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 20 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lafayette
(c) City or town Higginsville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Colbert

3. (b) If veteran, name war _____ 3. (c) Social Security No 500-10-5480

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Clementine Colbert 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased October 3rd 1889
(Month) (Day) (Year)

8. AGE: Years 57 Months -- Days 25 If less than one day
hr. _____ min. _____

9. Birthplace Commerce, Ga.
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Clementine Colbert
(b) Address Higginsville, Mo.

17. (a) Burial (b) Date thereof 10/30/46.
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Music Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address Higginsville, Mo.

19. (a) Oct 30 1946 (b) Clayton H. Landrum
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 28 day _____
year 1946 hour _____ minute 1 A - M.

21. I hereby certify that I attended the deceased from Oct 27
1946 to Oct 28 1946
that I last saw him alive on Oct 27 1946
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Valvular Disease many years
(with decaying infection)
Duration 1 yr.

Due to Arterio sclerosis - many years

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations [Signature]
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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. for Surgeon)
Address Oct 30 1946 Date signed Higginsville, Mo.

RECEIVED

District Health Officer No. 8;

District File Number _____

Date Filed 11-9-46

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 Robert R. Rickhoff

Licensed Embalmer No. 4284

P. O. Address HIGGINSVILLE, 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.