

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1203**

FILED JAN 29 1949

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. **13**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Kansas City Tuberculosis Hosp.		d. STREET ADDRESS (If rural, give location) 2725 Vine St.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Suaie E.	b. (Middle)	c. (Last) Coleman	(Month) January	(Day) 2	(Year) 1949

5. SEX female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Dec. 10, 1924	9. AGE (In years last birthday) 23	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Brownsville, Tennessee	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME James Coleman	13b. MOTHER'S MAIDEN NAME Jennie Mae Shaw	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME K. C. T. B. Hosp.	ADDRESS Leeds, Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **7-31**, 1944, to **Jan. 2**, 1949, that I last saw the deceased alive on **Jan. 2**, 1949, and that death occurred at **2:50P.m.**, from the causes and on the date stated above.

23a. SIGNATURE George K. Landis (Degree or title) M.D.	23b. ADDRESS K. C. T. B. Hosp.	23c. DATE SIGNED 1-2-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial & removal	24b. DATE 1-5-49	24c. NAME OF CEMETERY OR CREMATORY Franklin Cem.	24d. LOCATION (City, town, or county) (State) Franklin Kansas
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DATE REC'D BY LOCAL REG. 1-4-49	REGISTRAR'S SIGNATURE Seraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Mrs. J. W. Jones	ADDRESS 440 State Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed Bergene English.....

Licensed Embalmer No. 4105.....

P. O. Address 440 State Ave.....
N. C. Kansas

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.