

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43984

State File No.

FILED FEB 2 1952

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 5730

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 town) Kansas City	c. LENGTH OF STAY (In this place) Unknown	c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION General Hospital #2		d. STREET ADDRESS (If rural, give location) 518 Locust	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) George	b. (Middle)	c. (Last) Coleman	11	25	51

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Unknown Fayette, Mo.	12. CITIZEN OF WHAT COUNTRY? ?
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Unknown
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. I	16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruby Webb	ADDRESS 621 Locust
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypo-static congestion of lungs.	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Epilepsy		3533
II. 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) (Minute)	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 11-21-51, 19 , to 11-25-51, 19 , that I last saw the deceased alive on 11-25-51, and that death occurred at 5:20 p m., from the causes and on the date stated above.

23a. SIGNATURE E. Frank Ellis (Degree or title) MD	23b. ADDRESS 600 East 22nd Street	23c. DATE SIGNED 11-27-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial #1	24b. DATE 2-1-52	24c. NAME OF CEMETERY OR CREMATORY Blue Ridge Lawn	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
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DATE REC'D BY LOCAL REG. 12-31-51	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Stephen Biller	ADDRESS 1912 1/2
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 _____

working under my personal supervision.

Student Embalmer No.

Signed

E. Sterling Bell

Signed.....
Student Embalmer

Licensed Embalmer No. *3178*

P. O. Address *1212 mile*

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.