

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24467  
STATE FILE NUMBER  
3374  
Registrar's No.

FILED AUG 12 1957

Registration District No. 149 Primary Registration District No. 1002

with, welfare, public, service  
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
Items 18, 19, and 20, if correct, by a duly qualified coroner.  
MEDICAL CERTIFICATION  
Hugh H. Owens

9-25-57  
Items 18, 19, and 20, if correct, by a duly qualified coroner.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2518 Quinette St. Slay</u>		4. STREET ADDRESS (If outside, give location) <u>1112 W 45th</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LUCIENNE COLBRANT</u> First <u>Lucienne</u> Middle <u>Colbrant</u> Last <u>Colbrant</u>		4. DATE OF DEATH <u>7 15 57</u> Month <u>7</u> Day <u>15</u> Year <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hostess</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>T.W.A.</u>	11. BIRTHPLACE (City and state or country) <u>Belgium</u>
13. FATHER'S NAME <u>Charles U.E. Colbrant</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bussers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>489-44-3488</u>	17. INFORMANT <u>Mrs. Simone Jaddai Norfolk Va</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Causes of death undetermined</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pending Laboratory Exam</u> DUE TO (c) <u>(a) Acute Pulmonary edema etiology undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>4 1/2 to 5 months pregnancy</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Hugh H. Owens, Coroner</u>		22b. ADDRESS <u>1034 Prairie Bldg</u>	22c. DATE SIGNED <u>7-19-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>Sept 24, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Belgium</u>
24. FUNERAL DIRECTOR <u>Sebbeto's</u> ADDRESS <u>K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-19-57</u>	26. REGISTRAR'S SIGNATURE <u>Norm Minshall</u>

Ch. 7.30

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, ~~by~~ ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Forrest D. Collins*.....

Licensed Embalmer No. *47*

P. O. Address: *K. C. N.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

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