

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032597

STATE FILE NUMBER

FILED OCT 8 1958 Registration District No. 149 Primary Registration District No. 1005 Registrar's No. 4447

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|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Jackson</i>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Louisiana</i> b. COUNTY _____ |  |
| b. CITY (If inside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>             |  | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <i>New Orleans</i> <sup>817 C</sup> <sub>8</sub>                   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>General Hosp</i> |  | Length of stay in 1b <i>1 Day</i>  | d. STREET ADDRESS (If outside, give location) <i>419 Florida Blvd</i>              |
|   |  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><i>Lionel A. Colomb</i> |                               |   | 4. DATE OF DEATH<br>Month Day Year<br><i>9-17-58</i> |  |  |
| 5. SEX <i>Male</i>   | 6. COLOR OF RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Oct 5, 1893</i>               |  | 9. AGE (In years) <i>65</i><br>IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ |

|  |  |   |  |  |
|--|--|---|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during longest working life, even if retired)<br><i>Salesman</i> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Office Supplies</i> | 11. BIRTHPLACE (City and state or country)<br><i>New Orleans</i> | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>        |
| 13a. FATHER'S NAME<br><i>Henry C Colomb</i>  |  | 13b. MOTHER'S MAIDEN NAME<br><i>Hannie Read</i>             |  | 14. NAME OF HUSBAND OR WIFE<br><i>Ethel F Colomb</i> |

|  |   |  |                                    |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) (If yes, give dates of service)<br><i>No</i> | 16. SOCIAL SECURITY NO.<br><i>Unknown</i> | 17. INFORMANT<br><i>Jane M. Colomb</i> | Address<br><i>New Orleans, La.</i> |
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| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>1</i> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____                        |  | <i>H201</i>                                  |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><i>Myocardial Infarction</i> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|---|--|--|---|
| 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.)<br><i>Myocardial Infarction</i> |  |   |
| 20c. TIME OF INJURY<br>Hour _____<br>a.m. _____<br>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 \_\_\_\_\_ on the date stated above; and to the best of my knowledge, from the causes stated.

|  |                             |  |  |
|--|-----------------------------|--|--|
| 22a. SIGNATURE (Degree or title)<br><i>Hugh H. Owens</i> | 3                           | 22b. ADDRESS<br><i>1024 Pichon Blvd</i>        | 22c. DATE SIGNED<br><i>9-18-58</i>                                       |
| 23. BURIAL, CREMATION, REMOVAL (Specify)                 | 23b. DATE<br><i>9-18-58</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>?</i> | 23d. LOCATION (City, town, or county) (State)<br><i>New Orleans, La.</i> |

|   |                             |  |   |
|---|-----------------------------|--|---|
| 24. FUNERAL DIRECTOR<br><i>H. Tejasinas &amp; Son</i> | ADDRESS<br><i>15 E. 2nd</i> | 25. DATE RECD. BY LOCAL REG.<br><i>9-19-58</i> | 26. REGISTRAR'S SIGNATURE<br><i>Neva Marshall</i> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens



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 .....  
Signature of Student Embalmer

Signed John J. Moore .....

Licensed Embalmer No. 4729 .....

P. O. Address Kansas City .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.