

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-042553

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5700

FILED NOV 26 1962			
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Jackson</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>39yrs</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3441 Bales</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>Jackson</u></p> <p>c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>3441 Bales</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>		
<p>3. NAME OF DECEASED First Middle Last (Type or print) <u>Natalie S. Colston</u></p>			
<p>4. DATE OF DEATH Month Day Year <u>11 10 62</u></p>			
<p>5. SEX <u>Female</u></p>	<p>6. COLOR OR RACE <u>Negro</u></p>	<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>8-12-03</u></p>
<p>9. AGE (last birthday) <u>59</u></p>		<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>ex-ray technician</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Gen No 1</u></p>	
<p>11. BIRTHPLACE (City and state or country) <u>San Antonia, Texas</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>William McKinney</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Mamie Summerville</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>Mack Colston</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p>	
<p>16. SOCIAL SECURITY NO. <u>[redacted]</u></p>		<p>17. INFORMANT Address <u>Mack Colston 3441 Bales</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma lungs</u> (b) <u>Endometrial carcinoma</u> (c) <u>Cerebral Embolism</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p>			<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p>		<p>PART III. If deceased was female was there a pregnancy in last 90 days.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown.</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>			
<p>20c. TIME OF INJURY Hour Month, Day, Year</p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>			
<p>21. I attended the deceased from <u>6-20-60</u> to <u>11-10-62</u> and last saw her alive on <u>11-9-62</u></p> <p>Death occurred at <u>3:10</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE <u>Royall B. Fleming, MD</u> (Degree or title)</p>		<p>22b. ADDRESS <u>1433 E-19th St</u></p>	
<p>22c. DATE SIGNED <u>11-10-62</u></p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>	
<p>23b. DATE <u>11-13-62</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln</u></p>	
<p>23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u></p>		<p>24. FUNERAL DIRECTOR ADDRESS <u>Watkins Bros. Funeral Home 18th Benton</u></p>	
<p>25. DATE RECD. BY LOCAL REG. <u>11-12-62</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>	

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF Attending Physician

ROYALL B. FLEMING, M.D.

Nov. 10, 1962

Nov. 9, 1962

6-20-62 to 11-10-62

6-20-60 to 11-9-62

USE BLACK INK OR TYPEWRITER RIBBON

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 James P. Watten

Licensed Embalmer No. 4500

P. O. Address 18th Benton

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.

IF ANY PART OF THIS STATEMENT IS NOT SIGNED BY THE LICENSED EMBALMER, THIS STATEMENT IS VOID.