

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.
24457
3245

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Law Primary Registration District No. 1002
 City Kansas City, Mo. (No. 53rd & Highland)
 File No. 1-2244
 Registered No. 1-2244
 St. _____ Ward _____

2. FULL NAME Helen Coleman
 (a) Residence. No. 53rd & Highland Ave. St. Ward _____
 (Usual place of abode) Home of the aged (If nonresident give city or town and State)
 Length of residence in city or town where death occurred _____ yrs. _____ mos. 13 How long in U.S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow of John Coleman

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>85</u>	<u>-</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Pennsylvania
 (STATE OR COUNTRY)

10. NAME OF FATHER Thomas Haeder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Benn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
 (STATE OR COUNTRY)

14. INFORMANT S. Main August, exp. Little Sister of
 (Address) 53rd & Highland Ave. St. for

15. FILED 8-22-27 M.M. Carver
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-22-27

17. I HEREBY CERTIFY, That I attended deceased from _____
June, 1927, to Aug 22, 1927
 that I last saw her alive on Aug 20, 1927, and that death occurred, on the date stated above, at 6 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
apoplexy
85
7401
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS auto. & Post. exam.
 (Signed) A. Seck-Rout, M. D.
9-22-27 (Address) 1034 Apple Bed

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Mary's DATE OF BURIAL 8/23 1927

20. UNDERTAKER Funeral Home of Mrs. Leo Powell
 ADDRESS _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE IN FULL, WITH CHANGING INITIALS IS A PERMANENT RECORD

