DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35178

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4153

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS CITY (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ST LUKE'S HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY (If outside city or town limits, write "RURAL")

(d) Street No. 3915 WAYNE (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME MR. RUBIE HERBERT COLTON 435

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife MRS LANA COLTON

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 28 (Month) 1867 (Day) (Year)

8. AGE: Years 72 Months 4 Days 1 day If less than one day ..... hr. ..... min.

9. Birthplace Palos (City, town, or county) Kansas (State or foreign country)

10. Usual occupation DECORATOR

11. Industry or business

FATHER
12. Name G. Adolph COLTON
13. Birthplace ..... (City, town, or county) Vermont (State or foreign country)

MOTHER
14. Maiden name Phobe Dixon
15. Birthplace ..... (City, town, or county) Ohio (State or foreign country)

16. (a) Informant's own signature Lana Colton

(b) Address 3915 Wayne

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-39 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cantheon

18. (a) Signature of funeral director D. H. Newcomer's Sons

(b) Address 1401 BRUSH CREEK BLVD.

19. (a) 10/30/39 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 29 year 1939 hour 9.25 minute A. M.

21. I hereby certify that I attended the deceased from Oct 28-39, 19..., to Oct 29, 1939; that I last saw him alive on Oct 28, 1939; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary thrombosis	
Bronchial Pneumonia	
Due to: Infection 23	
Due to:	
Other conditions: Old pulmonary F.B. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature F. C. Rumsey (M. D. or other)

Address 311 Argyle Bldg Date signed 10/30-39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 X19511

311 Argyle Bldg.
12-5-38

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed George M. Collier

Licensed Embalmer No. 3839

P. O. Address K. C. Mo.

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, above space should be left blank.