

FILED FEB 21 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

4831

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>339</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>IOWA</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>1 MONTH</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>FORT MADISON</u>		13	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>NEUROLOGICAL HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>2</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>NORMAN</u> b. (Middle) <u>A.</u> c. (Last) <u>COLBY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 24 1949</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>UNKNOWN</u>	
9. AGE (In years last birthday) <u>66 YRS.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DENTAL SURGERY</u>		11. BIRTHPLACE (State or foreign country) <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNKNOWN</u>
13a. FATHER'S NAME <u>UNKNOWN COLBY</u>			13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MRS. ALMA B. COLBY</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT'S SIGNATURE OR NAME <u>HOSPITAL RECORDS</u> ADDRESS <u>KANSAS CITY MISSOURI</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tubercular meningitis with hemiplegia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>DIET</u>					INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>5 months</u>
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>1-21</u> , 19 <u>48</u> , to <u>1-24</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>1-23</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>G. Wilsie Robinson</u> (Degree or title) <u>Sec. (sic) Robinson M.D.</u>				23b. ADDRESS <u>2625 W. Paseo Kansas City Mo.</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JAN 24 1949</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>FORT MADISON IOWA</u>	
DATE REC'D BY LOCAL REG. <u>1-24-49</u>		REGISTRAR'S SIGNATURE <u>St. Pauline Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Pauline Holmes</u> ADDRESS <u>1401-BRAIN CREEK KANSAS CITY MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

Done

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.

Signed *Bernard L. Horan*

Signed _____
Student Embalmer

Licensed Embalmer No. *4250*

P. O. Address *A.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, fact should be so stated above.