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.

AUG 16 1939

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

26339
Do not use this space.

1. PLACE OF DEATH
(a) County New Madrid
(b) Township Como
(c) City
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registration District No. 605
Primary Registration District No. 4359
Registered No.

2. PRINT FULL NAME 245 Luther D. McCollum
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 27, 1864
7. AGE YEARS 74 MONTHS 6 DAYS 5 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ala

FATHER
13. NAME Aklin McCollum
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

MOTHER
15. MAIDEN NAME Neicie Jane Cannon
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Lee Redman Risco, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Malden DATE Aug 2, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) none
20. FILED Aug 2, 1939 Dr Geo W Husted Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 1, 1939
22. I HEREBY CERTIFY, That I attended deceased from June 1, 1939, to Aug 1, 1939
I last saw him alive on June 5, 1939. Death is said to have occurred on the date stated above, at 4P m.
The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage
Date of onset
Other contributory causes of importance: 82a
Name of operation Clinical Date of
What test confirmed diagnosis? Was there an autopsy? No
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury ....., 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Geo W Husted, M. D.
534 (Address) Parma

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer
District File Number 839-127
Date Filed 8-14

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.