

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

REG'D SEP 15 1939  
Registration District No. **96**

Primary Registration District No. **3038**

Registrar's No. **141**

1. PLACE OF DEATH:  
(a) County Saline  
(b) City or town Marshall  
(c) Name of hospital or institution: Fitzbibbons Hospital  
(d) Length of stay: In hospital or institution 7 days  
In this community Life

3. (a) PRINT FULL NAME Joyce Ann Colliver 416  
8. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug. 12-1939  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Saline County Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Baby  
11. Industry or business None

MOTHER FATHER { 12. Name Dale Colliver  
13. Birthplace Carroll Co Mo.  
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Paulene Jones  
15. Birthplace Brookfield, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dale Colliver  
(b) Address 619 North Hamner, Marshall

17. (a) Burial (b) Date thereof Aug. 20 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Ridge Park

18. (a) Signature of funeral director Don Short 712  
(b) Address 452 So. Odell Marshall Mo.

19. (a) 8-21-39 (b) Mary Kent  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Saline  
(c) City or town Marshall, Mo.  
(d) Street No. Lived a few days Hospital  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 19 year 1939 hour \_\_\_\_\_ minute 40 M.

21. I hereby certify that I attended the deceased from Aug 12 1939 to Aug 19 1939  
that I last saw her alive on Aug 19 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death: Stroke of the New born. 4 days convulsions  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: 161 hr  
(Include pregnancy within 3 months of death)  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Mary Kent (M. D. or other) \_\_\_\_\_  
Address Marshall Date signed 8/21/39

9/11/39  
District File Number  
District Health Officer No. 8

**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.....

*X*....., Registered Apprentice No. *X*  
working under my personal supervision.

Signed *Don Short*.....

Licensed Embalmer No. *3757*.....

P. O. Address *Marshall, 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.