

Registration District No. **605**

Primary Registration District No. **4559**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Dilbourn Pt 1**
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **2** (Specify whether)

In this community **40 yrs -** years, months or days

3. (a) PRINT FULL NAME **Joe O. Colaine**

3. (b) If veteran name war **X** 3. (c) Social Security No. **X**

4. Sex **Male** 5. Color or race **White** 7. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **unknown** 6. (c) Age of husband or wife if alive **22** years

7. Birth date of deceased **April 22 1863** (Month) (Day) (Year)

8. AGE: Years **77** Months **5** Days **4** If less than one day hr. min.

9. Birthplace **Madison** (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **John Colvin**

13. Birthplace **Missouri** (City, town, or county) (State or foreign country)

14. Maiden name **Sarah Knapp**

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Oscar Colvin**

(b) Address **Dilbourn**

17. (a) **Burial** (b) Date thereof **Sept 26 1940** (Month) (Day) (Year)

(c) Place: burial or cremation **Woodsdale**

18. (a) Signature of funeral director **Bill Brown**

(b) Address **Dilbourn**

19. (a) **9/27/40** (Date received local registrar) (b) **Dr. G. W. Duster** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **New Madrid**

(c) City or town **Dilbourn Pt 1** (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **26** year **1940** hour **7** minute **45** AM

21. I hereby certify that I attended the deceased from **July 15**, 19**40**, to **Sept 26**, 19**40**, that I last saw him alive on **Sept 25**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decomp.**

Due to _____

Due to _____

Other conditions (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 **Dr. G. W. Duster** (M. D. or other)

Address **Parma** Date signed **9/27/40**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

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RECEIVED

District Health Officer No. 2

District File Number 1040-1575

Date Filed 10/14/48

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 comply with the above constitutes grounds for revocation of license.)

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