

STANDARD CERTIFICATE OF DEATH

State File No. 12

Registration District No. 1076 Primary Registration District No. 5687 Registrar's No. 12

1. PLACE OF DEATH:

(a) County Swingaton  
 (b) City or town Avalon  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
on highway 65 north of County line  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
 In this community 27 years  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County..... J-9  
 (c) City or town..... 0  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No.....  
 (If rural, give location)  
 (e) Citizen of foreign country?..... (Yes or No) 0  
 If yes, name country.....

3. (a) PRINT FULL NAME William Henry Colter

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

4. Sex M 5. Color or race W  
 6. (a) Single, widowed, married, divorced, married  
 6. (b) Name of husband or wife Edna (Alexandra) Colter  
 6. (c) Age of husband or wife if alive 26 years (Day) (Year)  
 7. Birth date of deceased Nov. 26 1869  
 (Month) (Day) (Year)

8. AGE: Years 71 Months 5 Days 27  
 If less than one day hr. min.

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

10. Usual occupation farmer

11. Industry or business.....

12. Name William S. Colter  
 13. Birthplace.....  
 (City, town, or county) (State or foreign country)

14. Maiden name Amanda Jane Sutton  
 15. Birthplace.....  
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Edna Colter  
 (b) Address Avalon, Mo.

17. (a) burial (b) Date thereof 5 26 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Avalon

18. (a) Signature of funeral director Clifford W. Austin  
 (b) Address.....

19. (a) (b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23  
 year 1941 hour 10 minute 30 P. M.

21. I hereby certify that I attended the deceased from April 10 1941 to May 23 1941  
 that I last saw him live on May 21 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of Prostate Duration 2 years

Due to.....  
 Due..... 518

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Carcinoma of Prostate  
 Of 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?  
4/01 (Specify type of place) While at work? (e) Means of injury.....

23. Signature W. S. Colter (M. D. or other) 0  
 Address Avalon, Mo. Date signed 5/24/41

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

MOTHER FATHER

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.....

*Clifford W. Austin*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*Clifford W. Austin*

Licensed Embalmer No. *3233*

P. O. Address..... *Teno, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18340

Registration District No. 1076

Primary Registration District No. 5689

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Grand River, Mo.  
(If outside city or town limits, write "RURAL" and name of township)

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME W. M. Henry Colter

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>71</u>	<u>5</u>	<u>27</u>	_____ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Mrs. Chas. Ludwig  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

20. DATE OF DEATH: Month May day 23  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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 A. Collier (M. D. or other) \_\_\_\_\_  
Address Chillicothe, Mo. Date signed \_\_\_\_\_

SUPPLEMENTARY

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

