

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

28870

State File No. \_\_\_\_\_

Registration District No. 5505

Primary Registration District No. 5761

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

1. PLACE OF DEATH:

(a) County Miller  
(b) City or town Rural  
(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 Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Nelson, Mo. R#1  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ALLEN COLVIN

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

4. Sex Male 5. Color or race white  
6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Annie Colvin  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 23 - 1877  
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 13  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Miller Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name James Calvin  
13. Birthplace 1 Penn  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Shymake  
15. Birthplace 1 Penn.  
(City, town, or county) (State or foreign country)

16. (a) Informant William Colvin  
(b) Address Nelson, Mo.

17. (a) Burial (b) Date thereof Aug-6-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Calvin Cem. Rains, Mo.

18. (a) Signature of funeral director C. L. Casey  
(b) Address 804 41

19. (a) 804 41 (b) \_\_\_\_\_  
(District or local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5.  
year 1941 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug. 2 1941 to Aug 5 1941  
that I last saw him alive on Aug 4 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Duration 1 year

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature Myron D Jones (M.D. or other) DA  
Address Boltonley, Mo. Date signed 8-8-41

796 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

Miller County Health Dept.

County File Number 41-95

Date Filed 9/2/48

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

*Ch. Carey*

Licensed Embalmer No.

2694

P. O. Address

*Iberia - 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.