

AUG 7 1943
Registration District No. 282

Primary Registration District No. 5971

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Rural - Marionburg
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community most of life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Tom McColm

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

4. Sex male 5. Color or race W 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased February 8 1879
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER } 12. Name Philip McColm

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

14. Maiden name Mary Clark

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

16. (a) Informant Vesta Marshall

(b) Address Halfway Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-43 (Month) (Day) (Year)

(c) Place: burial or cremation Golf

18. (a) Signature of funeral director Lutteson & Co.

(b) Address Bolivar Mo.

19. (a) July 12 1943 (Date received local registrar) (b) Alice Palen (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 28 year 1943 hour 1:05 minute 9 A. M.

21. I hereby certify that I attended the deceased from June 1 to June 28 1943 that I last saw him alive on June 10 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Heart failure Duration _____

Due to Hypostatic Pneumonia

Due to Fracture of Hip

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) 084

(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 0

23. Signature D. W. K. ... (M. D. or other) 7-12-43

Address Bolivar Mo. Date signed _____

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

RECEIVED
District Health Officer No. 7
District File Number 7-43-772
Date Filed 8-6-43

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: Carl Pitts
Licensed Embalmer No. 3746
P. O. Address Bolivar, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 282

Primary Registration District No. 5971

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Polk
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Jam Mc Colm

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 S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Feb (Month) 8 (Day) 1943 (Year)

8. AGE: Years 64 Months 4 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____
19. (a) _____ (b) _____ (Registrar's signature)
(Date received local registrar)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan year 1943 day 28 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Heart failure Duration _____

Due to _____
Due to Suppurative pneumonia
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Fracture of hip PHYSICIAN _____
Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy See 10

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident - fall
(b) Date of occurrence about June 1, 1943
(c) Where did injury occur? Co farm Bolivar Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Co home
While at work? no (Specify type of place) (e) Means of injury fall
23. Signature Stuebner (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-25806