

FILED JUN 9 1944

Registration District No. _____

Primary Registration District No. 3038

Registrar's No. 330

1. PLACE OF DEATH:

(a) County LINN
(b) City or town BROOKFIELD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: TIO W DAKE /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58
(c) City or town New Boston Rural 0
(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 _____

3. (a) PRINT FULL NAME: JEFFERSON DAVIS McCOLLUM

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

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

6. (b) Name of husband or wife: Mary Ellen 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Jan 30 1862 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 27 If less than one day hr. min.

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

10. Usual occupation: Farmer

11. Industry or business: _____

MOTHER FATHER { 12. Name: John McCollum
13. Birthplace: Linn Co Mo (City, town, or county) (State or foreign country)
14. Maiden name: Elizabeth McCollum
15. Birthplace: Linn Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Melissa McCollum (b) Address: New Boston Mo

17. (a) Burial (b) Date thereof: 5 29-44 (Month) (Day) (Year)

(c) Place: burial or cremation: Nestle Chapel

18. (a) Signature of funeral director: _____ (b) Address: Brookfield Mo

19. (a) 5-28-44 (Date received local registrar) (b) W W Cowan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27th year 1944 hour 05 minute 30 AM

21. I hereby certify that I attended the deceased from 6-1 1943 to 5-27 1944 that I last saw him alive on 5-26 1944 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Myocarditis Duration 3-400
Due to: Pericarditis 6.441

Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: Of operations: 930
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: G E Ford M.D. or other Date signed: 5/28
Address: Brookfield

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

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. *4037*

P. O. Address *Bushlin 70*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

5-43
K36930

JUN 10

Registration District No. 184 Primary Registration District No. 2008 State File No. _____ Registrar's No. 330

1. PLACE OF DEATH:

(a) County Linn

(b) City or town Brookfield
(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 lifetime years, months or days

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 _____

3. (a) PRINT FULL NAME Jefferson D. McCallum

3. (b) If veteran name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1944 hour _____ minute _____ M.

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

Immediate cause of death _____

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife May Ellen

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Jan 30 1867
(Month) (Day) (Year)

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

8. AGE: Years 12 Months 3 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)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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) _____
(Date received local registrar) (Registrar's signature)

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

18532

18532