

FILED MAR 16 1945

State File No. _____

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 429

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:
426 E SEDGWICK
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NO (Specify whether)
In this community LIFETIME years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LINN 54
(c) City or town BROOKFIELD (If outside city or town limits, write "RURAL")
(d) Street No. 426 E. SEDGWICK (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE MARION McCOLLUM

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

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

6. (b) Name of husband or wife LINDRE McCollum 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Aug 26 1865 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>6</u>	<u>1</u>	hr. min.

9. Birthplace LINN Co MO (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Wm McCollum

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

14. Maiden name Sarah Harris (City, town, or county) (State or foreign country)

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

16. (a) Informant Wm Lindre McCollum

(b) Address 426 E Sedgwick Brookfield Mo

17. (a) Burial (b) Date thereof Feb 26 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cem

18. (c) Signature of funeral director Rust Funeral Home

(b) Address Brookfield MO 415 LINN

19. (a) 2-27-1945 (b) Wm Cowan (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25 year 1945 hour 11 minute 45 P.M.

21. I hereby certify that I attended the deceased from FEB 15 1945 19. to FEB 25 1945 19. I last saw him alive on Feb 25 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Thrombosis Duration 10 days

Due to _____

Due to _____

Other conditions: AKA (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 Wm Lucas MD (M.D. or other)

Address Brookfield Mo Date signed 2/27/45

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

8
1
2

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *E. A. Larson*.....

Licensed Embalmer No. *4037*.....

P. O. Address..... *Bucklin, 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.