No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41807

FILED DEC 29 1945

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 324

1. PLACE OF DEATH:
(a) County MARION
(b) City or town HANNIBAL
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: ST. ELIZABETH HOSP.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) 14 DAYS
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County MONROE
(c) City or town PARIS
(If outside city or town limits, write "RURAL")
(d) Street No. S. MAIN ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country ✓

3. (a) PRINT FULL NAME ROBERT T. COLBORN.
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOWED.
6. (b) Name of husband or wife ANNIE BELLE COLBORN
6. (c) Age of husband or wife if alive ✓ years
7. Birth date of deceased MAY (Month) 8 (Day) 1857 (Year)
8. AGE: Years 88 Months 5 Days 21 If less than one day hr. min.
9. Birthplace RALLS CO. (City, town, or county) MO. (State or foreign country)
10. Usual occupation MINISTER
11. Industry or business ✓
MOTHER FATHER
12. Name ARRON B. COLBORN
13. Birthplace PA. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name MARGRET ANN TAYLOR
15. Birthplace N.K. (City, town, or county) (State or foreign country)
16. (a) Informant R. Linn Colborn
(b) Address PARIS, MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 31, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation WALNUT GROVE
18. (a) Signature of funeral director Speed & Blakey
(b) Address Paris, Missouri.
19. (a) 11-3-45 (Date received local registrar) (b) R. E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 29 year 1945 hour 10 minute 55 P.M.
21. I hereby certify that I attended the deceased from Oct 20 45 to Oct 29 45
that I last saw him alive on Oct 29 45
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardio-Vascular-Renal	1
Syndrome Syndrome.	1
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 1/3/46	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D.)
Address [illegible] Date signed Nov 2-45

1344 (Licensed Embalmer's Statement on Reverse Side)

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 A. G. Blakey

Licensed Embalmer No. 2614

P. O. Address Paris, Missouri.

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.