

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **7692**

Registration District No. **MAR 7 1946**

Primary Registration District No. **1003**

Registrar's No. **18502**

1. PLACE OF DEATH:

(a) County _____

(b) City or town ST. LOUIS MO.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. JOHN'S HOSP.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-12-24-46
(Specify whether years, months or days)

In this community YES 12 DAYS

2. USUAL RESIDENCE OF DECEASED:

(a) State ILLINOIS (b) County 999

(c) City or town LOUISVILLE
(If outside city or town limits, write "RURAL") N.R.!

(d) Street No. _____ (If rural, give location) 5

(e) Citizen of foreign country? NO. (Yes or No) ✓

If yes, name country _____

3. (a) PRINT FULL NAME Fred McCollum Sr

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex MALE 5. Color or race WHITE

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

6. (b) Name of husband or wife NANCY E. McCollum

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased: DECEMBER 23 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation RETIRED

11. Industry or business BANKER

MOTHER FATHER { 12. Name WILLIAM W. McCollum

13. Birthplace CLAY COUNTY ILLINOIS
(City, town, or county) (State or foreign country)

14. Maiden name NANCY ANN TOLLIVER

15. Birthplace LAWRENCE COUNTY INDIANA
(City, town, or county) (State or foreign country)

16. (a) Informant FRED McCollum

(b) Address FLORA ILLINOIS

17. (a) Removal (b) Date thereof Feb 24-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Concordia Hill

18. (a) Signature of funeral director Walter F. Williams

(b) Address Concordia Hill

19. (a) FEB 25 1946 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEBRUARY day 24
year 1946 hour 5 minute 20 P.M.

21. I hereby certify that I attended the deceased from FEBRUARY 12, 1946, to FEBRUARY 24, 1946 that I last saw him alive on FEBRUARY 24, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death: GENERALIZED ARTERIO-SCLEROSIS

Due to _____

Due to _____

Other conditions HYPERTROPHIED PROSTATE
(Include pregnancy within 3 months of death)

Major findings: Of operations HYPERTROPHIED PROSTATE (SMALL TRANSURETHRAL PROSTATECTOMY)

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 C. Neilson Muller (M. D. or other) _____

Address Humboldt Bldg Date signed 2-24-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

6642

1859

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.....

P. O. Address.....

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.