

FILED FEB 13 1948

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44167
State File No.

Registration District No. 05

Primary Registration District No. 3011

Registrar's No. 262

1. PLACE OF DEATH:

(a) County **Carroll**
(b) City or town **Carrollton,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Atwood Hospital.**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 weeks,**
In this community **all her life,** (Specify whether years, months or days)

3. (a) PRINT FULL NAME.

Mollie Colliver,

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex **F**

5. Color or race **W**

6. (a) Single, widowed, married, divorced. **Widowed**

6. (b) Name of husband or wife **Wiley Colliver**

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

7. Birth date of deceased **May 6th, 1869**
(Month) (Day) (Year)

8. AGE: Years **78** Months **7** Days **20** If less than one day hr. min.

9. Birthplace **Mandiville, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper.**

11. Industry or business

12. Name **Mathew Breckenridge,**

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

14. Maiden name **Mary Jane Hill**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Mrs Francis Sample,**

(b) Address **Tina, Mo.**

17. (a) **Burial** (b) Date thereof **12/28/1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Coloma,**

18. (a) Signature of funeral director **Clifford W. Austin,**

(b) Address **Tina, Missouri.**

19. (a) **12/28/47** (b) **Mrs. Mabel Colwell**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Carroll** / 17
(c) City or town **Tina,** 0
(If outside city or town limits, write "RURAL")
(d) Street No. **4 miles N.W. Tina,** 0
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **XX**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **26th** day **De** **cember**
year **1947** hour **7:00** minute **A.** M.

21. I hereby certify that I attended the deceased from **July 1**, 1947, to **December 26**, 1947;
that I last saw him alive on **December 25**, 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Carcinoma of Gall bladder** Duration **14**

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **HOT**

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)
(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 **John H. P. Kelly M.D.** (M. D. or other)
Address **Carrollton, Missouri** Date signed **12/28/47**

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-11-48

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 _____

Clifford W. Austin

Licensed Embalmer No. 3233

P. O. Address Tina, 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.