

FILED MAR 8 1949 STANDARD CERTIFICATE OF DEATH

State File No. 5806  
Registrar's No. 525

BIRTH NO. 49-82022 REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3006

1. PLACE OF DEATH a. COUNTY -- Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Randolph	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moberly Mo		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION McCormick Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Higbee Mo Rural	
		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Janice	b. (Middle) Collcott	c. (Last) Collcott	4. DATE OF DEATH (Month) (Day) (Year) Feb 27 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH Dec 20 1948	9. AGE (In years last birthday) I 6	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) McCormick Hospital Moberly Mo	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Delbert Collcott	13b. MOTHER'S MAIDEN NAME Opal Johnson	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Delbert Collcott R. F. D. Higbee
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Feb 26, 1949, to Feb 27, 1949, that I last saw the deceased alive on Feb 27, 1949, and that death occurred at 9 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>V.L. Robinson</u>	23b. ADDRESS <u>205 Higbee, Mo.</u>	23c. DATE SIGNED <u>2-28-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb 28 1949	24c. NAME OF CEMETERY OR CREMATORY City Cem #444#	24d. LOCATION (City, town, or county) (State) Higbee Mo
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DATE REC'D BY LOCAL REG. Feb 28-49	REGISTRAR'S SIGNATURE <u>Leah Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Burton Funeral Home Higbee Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

88  
6  
3

RECEIVED

District Health Officer No. 10

District File Number 3-49-418

Date Filed \_\_\_\_\_

MAR 7 - 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

*Max Embalm*  
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.