

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14581**

FILED APR 19 1949

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD.

BIRTH NO. _____		REG. DIST. NO. <u>338</u>		PRIMARY REG. DIST. NO. <u>4561</u>		Registrar's No. <u>18</u>								
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u>										
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bloomfield</u>		c. LENGTH OF STAY (In this place) <u>1</u> Years		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bloomfield</u>										
d. FULL NAME OF HOSPITAL OR INSTITUTION ---				d. STREET ADDRESS (If rural, give location)										
3. NAME OF DECEASED (Type or Print) <u>John Clarence Mc Collum</u>			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 21, 1949</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 7, 1888</u>		9. AGE (In years last birthday) <u>60</u>		10. UNDER 1 YEAR Months <u>8</u> Days <u>14</u>		11. UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <u>Stoddard co., Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>US.</u>				
13a. FATHER'S NAME <u>J. T. Mc Collum</u>				13b. MOTHER'S MAIDEN NAME <u>Martha Lucas</u>				14. NAME OF HUSBAND OR WIFE <u>Eva E. Mc Collum</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Eva Mc Collum</u> ADDRESS <u>Bloomfield, Mo.</u>								
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CHRONIC MYOCARDITIS</u>								INTERVAL BETWEEN ONSET AND DEATH <u>YES</u>		
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROSIS</u>								<u>YES</u>		
				DUE TO (c) <u>4.2.2. V</u>										
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>CEREBRAL HEMORRHAGE</u>								<u>10 DAYS</u>		
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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)								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?						
22. I hereby certify that I attended the deceased from <u>MAR 16, 1949</u> , to <u>MAR 21, 1949</u> , that I last saw the deceased alive on <u>MAR 21, 1949</u> , and that death occurred at <u>5 P. m.</u> , from the causes and on the date stated above.														
23a. SIGNATURE (Name or title) <u>[Signature]</u>						23b. ADDRESS <u>W. 2. Bloomfield</u>			23c. DATE SIGNED <u>3-28-49</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar. 23, 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Walkers cemetery</u>			24d. LOCATION (City, town, or county) (State) <u>Stoddard co. Mo.</u>							
DATE REC'D BY LOCAL REG. <u>April 12-49</u>		REGISTRAR'S SIGNATURE <u>Rose Webber</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>CHILES UNDERTAKING CO.</u> ADDRESS <u>Blfd. Mo.</u>								

RECEIVED
District Health Office No. _____
District File Number 449-4946
Date Filed 4-18-49

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 _____

Lulu Cooper # 3499

Student Embalmer No. _____

working under my personal supervision.

Signed Lulu B. Cooper

Signed.....
Student Embalmer

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.