

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12338**

FILED APR 28 1952

BIRTH NO. _____ REG. DIST. NO. **64** PRIMARY REG. DIST. NO. **5248** Registrar's No. **32**

1. PLACE OF DEATH a. COUNTY Chariton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Chariton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Wayland Twp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Wayland Twp	
c. LENGTH OF STAY (In this place) Life		d. STREET ADDRESS (If rural, give location) 0210	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Isaac c. (Last) McCullum			4. DATE OF DEATH (Month) (Day) (Year) 4-23-1952			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May-9-1880	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John W McCollum	13b. MOTHER'S MAIDEN NAME Flora Parker	14. NAME OF HUSBAND OR WIFE Lillie McAvan McCollum
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME Albert McCollum	ADDRESS Salisbury Mo
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5 yrs.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 334X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	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 **4-16**, 19**52**, to **4-23**, 19**52**, that I last saw the deceased alive on **4/23**, 19**52**, and that death occurred at **12 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE H. W. Haworth MA (Degree or title)	23b. ADDRESS Salisbury Mo	23c. DATE SIGNED 4-25-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-25-52	24c. NAME OF CEMETERY OR CREMATORY Old Prairie Hill Cen	24d. LOCATION (City, town, or county) (State) Chariton Mo
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DATE REC'D BY LOCAL REG. 4/25/52	REGISTRAR'S SIGNATURE H. W. Haworth	55	25. FUNERAL DIRECTOR'S SIGNATURE Chas B. W. Meyers	ADDRESS Salisbury
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Signed

Las B. Vinkelman

Licensed Embalmer No.

3842

P. O. Address

Salisbury Md

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.