

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 10 - 1955

State File No. 30479

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 199

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1008 Howell St.</u>		e. STREET ADDRESS (If rural, give location) <u>1008 Howell St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ISABEL</u>	b. (Middle) <u>MARY</u>	c. (Last) <u>KOLB</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>October 1, 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MAY 26 1880</u>	9. AGE (In years last birthday) <u>75</u>	if UNDER 1 YEAR Months <u>4</u> Days <u>3</u>	if UNDER 6 WKS. Hours <u></u> Mins. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Elkhorn, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John M.B. Clark</u>	13b. MOTHER'S MAIDEN NAME <u>Nellie Parker</u>	14. NAME OF HUSBAND OR WIFE <u>Charles E. Kolb</u>
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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>Raymond Kolb, St. Charles, Mo.</u>	ADDRESS <u>St. Charles, Mo.</u>
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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 <u>24 hr</u> <u>3 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>331X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cholecystitis</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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?
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22. I hereby certify that I attended the deceased from Oct 1, 1955, to October 1, 1955, that I last saw the deceased alive on Oct 1, 1955, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>W.A. Poggenius</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>St. Charles, Mo.</u>	23c. DATE SIGNED <u>October 1, 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Oct. 3, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Monroe Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Atlantic, Iowa</u>
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DATE REC'D BY LOCAL REG. <u>Oct 3 1955</u>	REGISTRAR'S SIGNATURE <u>Francis H. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Nathaniel C. ...</u> ADDRESS <u>St. Charles, Mo.</u>
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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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 437

P. O. Address J. Charles

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.