

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. GOOD 32802
State File No.

FILED OCT 17 1955

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 884

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). - a. STATE MISSOURI b. COUNTY WRIGHT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (in this place) 4 DAYS	c. CITY OR TOWN MT. GROVE
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		e. STREET ADDRESS (If rural, give location) R. F. D.	

3. NAME OF DECEASED (Type or Print)	a. (First) I. LOU	b. (Middle) ELLA	c. (Last) COLVIN	4. DATE OF DEATH (Month) (Day) (Year) OCT. 8 1955
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JAN. 3, 1874	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR (Months) 9	IF UNDER 2 HRS. (Hours) 5	IF UNDER 15 MIN. (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER	10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSE	11. BIRTHPLACE (City and State or Foreign Country) BOONE COUNTY MISSOURI	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME WILLIAM CALVIN	13b. MOTHER'S MAIDEN NAME JULIETTA JACKSON	14. NAME OF HUSBAND OR WIFE X
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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) NO	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS MRS. HORACE WILLIAMS ELIZABETH, 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, asphyxia, 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) Coronary Artery Thrombosis		
	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) m.	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 4, 1955, to Oct 8, 1955; that I last saw the deceased alive on Oct 7, 1955, and that death occurred at 9:25 A., from the causes and on the date stated above.

23a. SIGNATURE (Degree & title) James T. Good MD	23b. ADDRESS Springfield, Mo	23c. DATE SIGNED 10-10-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE OCT. 8, 1955	24c. NAME OF CEMETERY OR CREMATORY Marshall	24d. LOCATION (City, town, or county) (State) MT GROVE, MISSOURI
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DATE REC'D BY LOCAL REG. 10-11-55	REGISTRAR'S SIGNATURE Elizabeth Williams	FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS HERMAN LOHMEYER SPRINGFIELD, MO.
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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.....
Signature of Student Embalmer

Signed..... *Lucien T. Swadlow*

Licensed Embalmer No. *4815*

P. O. Address *Spring*

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.