

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-017223
STATE FILE NUMBER

FILED JUN 5 1958

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 116

300
1-57

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1. PLACE OF DEATH a. COUNTY AUDRAIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico Mo		c. CITY OR TOWN Independence Mo 1005	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain Hospital		d. STREET ADDRESS (If outside, give location) 1 day	
3. NAME OF DECEASED (Type or print) First Middle Last Mattie Glenn COLSTON			4. DATE OF DEATH Month Day Year 5 28 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or country) Callaway County Mo
13a. FATHER'S NAME Milton Schoell		13b. MOTHER'S MAIDEN NAME Carrie Cobb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 500-206278	
17. INFORMANT Denin Schoell			Address Martinsburg Mo
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS			YEARS
DUE TO (c) 4201			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) A NEURISM ABD. AORTA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month Day Year p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from 5-28-58 to 5-28-58 and last saw him alive on 5-28-58 Death occurred at 11:50 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Leonard Lewis MD		22b. ADDRESS Mexico Mo	
22c. DATE SIGNED 5-29-58			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 5-31-58	23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery	
23d. LOCATION (City, town or county) Independence Mo.		(State)	
24. FUNERAL DIRECTOR A. P. Kelly		25. DATE RC'D. BY LOCAL REG. May 29-1958	26. REGISTRAR'S SIGNATURE Blanche Keely

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Howard L. Myers*

Licensed Embalmer No. *4494*

P. O. Address *Willaville, W.*

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.