

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022506

STATE FILE NUMBER 20

FILED JUL 10 1958

Registration District No. 182 Primary Registration District No. 2682 Registrar's No. 20

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Linn</b>	
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) <b>North Salem Twp.</b>		c. CITY OR TOWN <b>RFD New Boston</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>RFD New Boston</b>		Length of stay in lb <b>40 yrs</b>	
3. NAME OF DECEASED (Type or print) <b>EARL C. McCOLLUM</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1896</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own farm</b>	11. BIRTHPLACE (City and state or country) <b>Adair County, Missouri</b>
13a. FATHER'S NAME <b>John B. McCollum</b>		13b. MOTHER'S MAIDEN NAME <b>Mary A. Wallace</b>	14. NAME OF HUSBAND OR WIFE <b>Fay McCollum</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	17. INFORMANT Address <b>Mrs. Earl McCollum, Winigan, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>4201</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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 _____ a.m. _____ p.m. _____		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>4/1/58</b> to <b>6/27/58</b> and last saw him alive on <b>6/22/58</b> Death occurred at <b>12:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>J.P. Mulligan</b>		22b. ADDRESS <b>Mo.</b>	
22c. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 29, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Price Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Winigan, Mo.</b>	
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>July 9, 1958</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Birdie Kelley</b>			

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 *Harold B. Wright* .....

Licensed Embalmer No. 3718 .....  
P. O. Address Brookfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.,  
If this body is not embalmed, fact should be so stated above.