

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044949  
STATE FILE NUMBER

FILED DEC 22 1958

Registration District No. 218 Primary Registration District No. 5788 Registrar's No. 42

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Mississippi</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Mississippi</u>		
b. CITY (If outside corporate limits, give township only) OR <u>Mississippi</u> TOWN <u>Concord Community</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Rt. # 1 Charleston.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Length of stay in lb <u>15 Yrs</u>	d. STREET ADDRESS (If outside, give location) <u>Rt # 1 Charleston</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Newton</u> Last <u>Comstock</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24, 1892</u>	9. AGE (In years last birthday) <u>65</u>	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) <u>Ret Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Elizabeth, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Wm Comstock</u>		13b. MOTHER'S MAIDEN NAME <u>Mattie Reynolds</u>		14. NAME OF HUSBAND OR WIFE <u>Zettie Comstock</u>	
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>- - - - -</u>	17. INFORMANT Address <u>Wm. Comstock Rt # 1 Charleston, Mo</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ART. SCLER. HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____ <u>4200</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS, Ess. HYPERTENSION</u>					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. 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 <u>Oct. 1957</u> to <u>11.30.58</u> and last saw her alive on _____ Death occurred at <u>7:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Carl G. Toppp M.D.</u>			22b. ADDRESS <u>STKESTON, Mo</u>		22c. DATE SIGNED <u>12.3.58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec 5, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>		23d. LOCATION (City, town, or county) (State) <u>Charleston, Missouri</u>
24. FUNERAL DIRECTOR <u>Mc Mikle Charleston, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12-16-58</u>		REGISTRAR'S SIGNATURE <u>Gertrude G. Harper</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

County File No. \_\_\_\_\_  
Date Filed 12-18-58

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 *Alfred Metcalfe*

Licensed Embalmer No. 4696  
P. O. Address Charleston

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.