

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-018088

STATE FILE NUMBER

FILED JUN 4 1959

Registration District No. 150

Primary Registration District No. 4241

Registrar's No. 129

1. PLACE OF DEATH a. COUNTY Jackson		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 Oak Grove		c. CITY OR TOWN Oak Grove	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City		Length of stay in 1b 35 Yrs	
3. NAME OF DECEASED (Type or print) Benjamin W Colvin		4. DATE OF DEATH Month Day Year May 27 1959	
5. SEX Male	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Funeral Home Empl		10b. KIND OF BUSINESS OR INDUSTRY H	11. BIRTHPLACE (City and state or country) Oak Grove Mo
13a. FATHER'S NAME James Colvin		13b. MOTHER'S MAIDEN NAME Mary Shenk	
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. 443-05-6777	
17. INFORMANT Allie P Colvin		Address Oak Grove 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) Cerebral Thrombosis			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) Myocardial Infarction			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332X			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 a.m. _____ p.m. _____		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
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.) _____	
21. I attended the deceased from Jan 1959 to May 26, 59 and last saw him alive on 5/26/1959 Death occurred at 1246 11th m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE James W. Colvin (Degree or title) MD		22b. ADDRESS Blair Grove Mo	
22c. DATE SIGNED 5/27-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE May 29 1959	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem	23d. LOCATION (City, town, or county) (State) Oak Grove Mo
24. FUNERAL DIRECTOR Webb Funeral Home ADDRESS Oak Grove Mo		25. DATE RECD. BY LOCAL REG. 5-28-1959	25. REGISTRAR'S SIGNATURE W B Langford

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JUN 10 1956

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 *[Handwritten Signature]*

Licensed Embalmer No. *2352*

P. O. Address *Blue Springs*

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.