

**FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-028191**

FILED VS SEP 8 1959

STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 5/20 Registrar's No. 4020  
402

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia Township</u>		Length of stay in 1b <u>6 yrs</u>		c. CITY OR TOWN <u>Columbia</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>Boone County Rest Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5 miles NE Columbia</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Kollman</u> Last <u>Kollman</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1959</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/1875</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Kenosha, Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>Nicholas Roders</u>				13b. MOTHER'S MAIDEN NAME <u>Margaret Peters</u>				14. NAME OF HUSBAND OR WIFE <u>Deceased</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>Mrs. J. H. Buchanan Col., Mo.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u>										<u>36 hrs</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <u>Cerebral Hemorrhage</u>		<u>48 hrs</u>	
										DUE TO (c) <u>Cardio - renal Disease</u>		<u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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 <u>  </u> Month, Day, Year <u>  </u>		a.m. <u>  </u> p.m. <u>  </u>											
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>1958</u> to <u>8-29-59</u> and last saw her <u>8-29-59</u> <sup>her</sup> <sub>him</sub> alive on <u>8-29-59</u> Death occurred at <u>3:30 AM 8-31-59</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>D.O.</u>					22b. ADDRESS <u>511 Christian College Ave., Columbia, Mo.</u>					22c. DATE SIGNED <u>8-31-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9/1/59</u>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) <u>Kenosha, Wisconsin</u>						
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u> ADDRESS <u>Columbia, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>Aug. 31 1959</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. R. E. Palmer</u>							

UNDE

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed *Ignace H. Spruck*

Licensed Embalmer No. 4013

P. O. Address Columbia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.