

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 5 1960

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STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 295

ENDED

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Livingston</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Length of stay in 1b <u>39 yrs.</u>		c. CITY OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>155 Brunswick</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Levia</u> Last <u>Colvin</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>Male</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>2/26/97</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drayman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial hauling</u>		11. BIRTHPLACE (City and state or country) <u>Latham, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>George Colvin</u>			13b. MOTHER'S MAIDEN NAME <u>Jennie Allison</u>			14. NAME OF HUSBAND OR WIFE <u>XX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes W.W.I</u>			16. SOCIAL SECURITY NO. <u>190-10-4502</u>		17. INFORMANT Address <u>Paul L. Colvin Jr., St. Joseph, 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>Chronic myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>(1) Phenomena from Return (2) Diabetes (3) Uremia</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m. Month, Day, Year _____							
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>1950</u> to <u>12-28-59</u> and last saw ^{her} him alive on <u>12-28-59</u> Death occurred at <u>10:55p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph F. Gale M.D.</u>				22b. ADDRESS <u>Chillicothe Mo</u>			22c. DATE SIGNED <u>12-30-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>12/31/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wheeling cemetery</u>		23d. LOCATION (City, town, or county) <u>Wheeling, Mo.</u>		(State)
24. FUNERAL DIRECTOR <u>Donald Gordon, Chillicothe, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Francis B. Velle</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB 9 1960

JAN 20 1960

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 Richard H. Banda

Licensed Embalmer No. 4866

P. O. Address Chillicothe,

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.