

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 11 1960

65 -60-034339

STATE FILE NUMBER

Registration District No. 113 Primary Registration District No. 4185 Registrar's No. 65

1. PLACE OF DEATH a. COUNTY Franklin				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Clair		Length of stay in 1b		c. CITY OR TOWN St. Clair		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 705 S. Commerical			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 705 S. Commerical		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mabel Lee Colbert				4. DATE OF DEATH Month Day Year October 6, 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Feb. 13, 1909	9. AGE (last birthday) 51	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and state or country) Washington County, Mo.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Leslie B. Horton			13b. MOTHER'S MAIDEN NAME Bessie Seabourne		14. NAME OF HUSBAND OR WIFE Floyd Colbert			
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. 492 20 9926		17. INFORMANT Floyd Colbert		Address St. Clair, 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) <u>CORONARY THROMBOSIS</u>							INTERVAL BETWEEN DEATH AND DEATH <u>minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>PARVOUS CRANIAL VASC. ACCIDENT</u>		DUE TO (c)		6 mo		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Severe Bronchial Asthma</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 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>1955</u> to <u>DEATH</u> and last saw her <u>live</u> on <u>Sept 1 - 60</u> Death occurred at <u>2:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>John F. Pearl, M.D.</u> (Degree or title)				22b. ADDRESS <u>St Clair, Mo</u>		22c. DATE SIGNED <u>10-7-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Caledonia Cemetery		23d. LOCATION (City, town, or county) (State) Caledonia, Missouri				
24. FUNERAL DIRECTOR Casey-Lenox		ADDRESS St. Clair, Mo.		25. DATE RECD. BY LOCAL REG. Oct 7 - 60	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 14 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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. M. Lenoir, Jr.

Licensed Embalmer No. 5090

P. O. Address St. Clair

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.