

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-028512

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 277

AMENDED

FILED SEP 5 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Butler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Poplar Bluff</u>		Length of stay in 1b	c. CITY OR TOWN <u>Poplar Bluff</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>Doctor's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>821 Chautauqua Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Paralee</u> Last <u>McColgan</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1961</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>6-7-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired house-keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>91</u> IF UNDER 1 YEAR IF UNDER 24 HR. Months <u>2</u> Days <u>7</u> Hours <u></u> Min. <u></u>
11a. BIRTHPLACE (City and state or country) <u>Enfield, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Albert Biggerstaff</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Gillham</u>	14. NAME OF HUSBAND OR WIFE <u>John W. McColgan (Dec'd)</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.	17. INFORMANT Address <u>Miss Reba McColgan, Dexter, 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>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bilateral Pneumonia</u> <u>5 days</u> DUE TO (c) <u>Fractured hip</u> <u>17 days</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
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell at home</u>	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u>7-29-61</u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION <u>Dexter</u>	COUNTY <u>Stoddard</u> STATE <u>Mo.</u>
21. I attended the deceased from <u>8:30 P. M.</u> to <u></u> and last saw her/him alive on <u></u> . Death occurred at <u>8:30 P. M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Mewie R. Barbour, MD</u>		22b. ADDRESS <u>Poplar Bluff, Mo</u>	22c. DATE SIGNED <u>8-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dexter</u>	23d. LOCATION (City, town, or county) (State) <u>Dexter, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Rainey Funeral Home, Dexter, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>8/31/1961</u>	26. REGISTRAR'S SIGNATURE <u>Thelma Gahan</u>

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 Lucille Rainey

Licensed Embalmer No. 4983

P. O. Address Dexter, Mo

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.