PLACE OF DEATH

County [redacted]

Township Lawrence Co

or

Village Pierce City

or

City ~~Monett Mo~~ (NO. _____ St.: _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 471 File No. 2 17515

Primary Registration District No. 4284 Registered No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Chas N Collom

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	~~SINGLE~~ MARRIED ~~WIDOWED~~ ~~OR DIVORCED~~ (Write the word)
Male	White	Married

DATE OF BIRTH July (Month) 26 (Day), 1867 (Year)

AGE 50 yrs. 9 mos. 27 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 1228 95A

BIRTHPLACE (City or town, State or foreign country) Ill 1798

PARENTS

NAME OF FATHER John C Collom

BIRTHPLACE OF FATHER (City or town, State or foreign country) Ill

MAIDEN NAME OF MOTHER Julia Vance

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C N Collom

(ADDRESS) Pierce City Mo

Filed May 24, 1918 J E Bonhill REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May (Month) 22 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from May 21, 1918, to May 22, 1918, that I last saw him alive on May 22, 1918, and that death occurred, on the date stated above, at 7:30 p m.

The CAUSE OF DEATH* was as follows: Heart Block following Ether Anesthetic given during operation to remove intestinal obstruction (Duration) 1 yrs. 10 mos. ___ ds.

Contributory (SECONDARY) Intestinal obstruction due to adhesions (Duration) ___ yrs. ___ mos. 2 ds.

(Signed) H. Ross Clark M. D.

5/23/18, 191__ (Address) Pierce City, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. 2 ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? Pierce City, Mo

Former or usual residence Pierce City, Mo

PLACE OF BURIAL OR REMOVAL Pierce City Mo

DATE OF BURIAL May 24 1918

UNDERTAKER John Seafert

ADDRESS Pierce City Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HE
BUREAU OF VITAL STATISTIC
CERTIFICATE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.: ..... Ward) [If death hospital or give its N of street an

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day) ..... (Year)

AGE ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191..., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day)

I HEREBY CERTIFY, that I attended dece

....., 191..., to .....

that I last saw h..... alive on .....

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos.

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos.

(Signed) .....

....., 191... —(Address) .....

*State the Disease Causing Death, or, in deaths from Violent (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRA RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mo

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BUR
UNDERTAKER	ADDRESS

Missouri Senate
50 General Assembly

VON MAYES
CHAIRMAN
COMMITTEE ON
RAILROAD AND INTERNAL IMPROVEMENTS