

Registration District No. H 31

Primary Registration District No. 5589

Registrar's No. 143

1. PLACE OF DEATH:
(a) County Johnson
(b) City or town Centerville, Mo. Country
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Johnson
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Marguerite Anna Colster
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec - day 23
year 1939 hour 1:30 minute A M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced ✓
(b) Name of husband or wife John Colster 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July - 7 - 1857
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 12-20, 1939 to 12-23, 1939
that I last saw her alive on 12-23, 1939
and that death occurred on the date and hour stated above.
Immediate cause of death Broncho-pneumonia with circulatory collapse Duration 1 day

8. AGE: Years 82 Months 5 Days 9 If less than one day _____ hr. _____ min.

Due to Fracture of Hip - left (intertrochanteric)

9. Birthplace St. Louis Co. Mo.
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Housekeeper

Other conditions (Include pregnancy within 3 months of death) _____

11. Industry or Business _____
12. Name John Bellman
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Lambert
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Robert G. ...
(b) Address Centerville Mo RFD

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) no
(b) Date of occurrence _____

17. (a) Burial (b) Date thereof Dec 25-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

18. (a) Signature of funeral director Suberney Phillip
(b) Address Warrensburg Mo
19. (a) Dec 26-39 (b) Eva Bentley 391
(Date received local registrar) (Registrar's signature)

While at work? E (Specify type of place) (e) Means of injury _____
23. Signature CR Cooper MD (M. D. or other) _____
Address Warrensburg Mo Date signed 12-23-39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

REV. 3-17-35

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

144

Date Filed 11/17/40
District File Number
District Health Officer No. 8

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.....

.....*Earl Priest*....., Registered Apprentice No.....
working under my personal supervision.

Signed *Earl Priest*

Licensed Embalmer No. *3878*

P. O. Address *Waverlyburg 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

43777

Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 431
 (b) Township Centerview Primary Registration District No. 35-89
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Marquesite Anna Colister

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 5 9

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Dec 19 1939 Eva Lentz Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 23 1939

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) E. R. Cooper, M. D.

(Address) Warrensburg Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should be stated EXACTLY. PL. & C. & S. No. should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

43777
Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 431
(b) Township Centerville Primary Registration District No. 3589 Registered No. 143
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Marquerite Anna Colister
(a) Residence, No. St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
82 5 9

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

FATHER
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

MOTHER
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19. _____

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED 19. _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 23, 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, to _____, 19...
I last saw h. alive on _____, 19... Death is said to have occurred on the date stated above, at _____ m.
The principal cause of death and related causes of importance were as follows:
Broken Pneumonia with Circulatory Collapse
Fracture of Hip Joint
Other contributory causes of importance:
Intertracheal 12-20-39

Name of operation NO Date of _____
What test confirmed diagnosis? Clin Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Accident Date of injury 12-20-39
Where did injury occur? RFD - Centerville, Mo.
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Home
Manner of injury Fall on Hip
Nature of injury Fracture, intertracheal h. Hip

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____ M. D.
(Signed) E. R. Cooper
(Address) Warrensburg, Mo.

SUPPLEMENT

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Local Registrar.