

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

Rev. 5-17-39
1 x1251

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 7 - 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **77089**
Registrar's No. **29**

Registration District No. **431**

Primary Registration District No. **5589**

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Centerview Rural**
(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
In this community **60** years, months or days

3. (a) PRINT FULL NAME **Joseph J. Colster**

8. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **male**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **April 26 1859**
(Month) (Day) (Year)

8. AGE: Years **80** Months **9** Days **17**
If less than one day hr. min.

9. Birthplace **Hanover, Germany**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Theodore Colster**

13. Birthplace **Hanover, Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Hanover, Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Robert Colster**

(b) Address **Centerview Mo.**

17. (a) **Burial** (b) Date thereof **Feb-17-1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Johns, Tenn.**

18. (a) Signature of funeral director **Sweeney Phillips**

(b) Address **Warrensburg, Mo.**

19. (a) **Feb 19-1940** (b) **Evelyn Bentley**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Johnson**
(c) City or town **Centerview 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. **Hanover, Germany** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **15**
year **1940** hour **10:50 A** minute **A** M.

21. I hereby certify that I attended the deceased from **Feb-1-40**
to **2-15-40**, 19____, to **2-15-40**, 19____
that I last saw him alive on **2-10-40**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis** Duration **?**

Due to _____

Due to **PTC**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(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?

While at work? (Specify type of place) (e) Means of injury

28. Signature **R F McHenry** (M. D. or other)

Address **Warrensburg Mo** Date signed **Feb-15-40**

RECEIVED
Health Officer No. 8
File Number 3/17/40
Date Filed

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 Warrensburg, 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.