

No. 2
-12-45
5-17-39
I X47070

Registration District No. **316** Primary Registration District No. **6075**

FILED MAY 27 1947

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 yrs. 4 mos. 19 as.
(Specify whether years, months or days)

In this community _____
years, months or days)

3. (a) PRINT JEANETTA (JENNET'PA) COLSTON
FULL NAME

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife J. W. Fisher (1st. or 2nd.) 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased July 9, 1893
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>53</u>	<u>9</u>	<u>17</u>	hr. _____ min.

9. Birthplace Shelby County, Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name W. C. Colston

13. Birthplace Lincoln County, Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Sattie Wuebb

15. Birthplace Shelby County, Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 4-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Cem., Farmington

18. (a) Signature of funeral director Berl Miller Funeral Home

(b) Address Farmington, Missouri

19. (a) 5-23-47 (b) Ether Redboff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin 94

(c) City or town Senath
(If outside city or town limits, write "RURAL")

(d) Street No. Unknown
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26
year 1947 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from December 7, 1924 to April 26, 1947 19____
that I last saw h. et. alive on April 26, 1947 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral ~~arteriosclerosis~~ ^{arteriosclerosis}
sclerosis

Duration Unknown
Day

Due to _____

Due to _____

Other conditions: Heart deficiency - Infarct
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy No 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?
Yes Home Doctor's office

23. Signature Frank J. Hittels (M. D. REGULAR)

Address Farmington, Missouri Date signed 5-2-47

RECEIVED

District Health Officer No. 4

District File Number 547-75

Date Filed 3-26-47

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 not
embalmed, Registered Apprentice No. _____,
working under my personal supervision.

Signed Paul Dupal

Licensed Embalmer No. 4120

P. O. Address Larrington, N.C.

* 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, fact should be so stated above.