No. 300
10-48

FILED APR 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12185

BIRTH NO. _____ REG. DIST. NO. 387 PRIMARY REG. DIST. NO. 5165 Registrar's No. 9

1. PLACE OF DEATH
a. COUNTY Callaway
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Guthrie
c. LENGTH OF STAY (in this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) In town

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Callaway
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Guthrie
d. STREET ADDRESS (If rural, give location) In town

3. NAME OF DECEASED (Type or Print) a. (First) Martin b. (Middle) A. c. (Last) Colter

4. DATE OF DEATH (Month) (Day) (Year) April 11, 1950

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH June 2, 1869
9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months 10 Days 9 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Absom Colter
13b. MOTHER'S MAIDEN NAME Ellen
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S SIGNATURE OR NAME Mable Colter ADDRESS Guthrie Mo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Disease (Organic)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Valvular Heart Disease
DUE TO (c) (Supp. report)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4.5 ?

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1950, *to* April 11, 1950, *that I last saw the deceased alive on* April 1, 1950, *and that death occurred at* X *m., from the causes and on the date stated above.*

23a. SIGNATURE E. McDuck (Degree or title) M.D.
23b. ADDRESS New Bloomfield Mo
23c. DATE SIGNED April 11-1950

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE April 13 1950
24c. NAME OF CEMETERY OR CREMATORY Riverview
24d. LOCATION (City, town, or county) Jefferson City (State) Mo.

DATE REC'D BY LOCAL REG. Apr 13-50
REGISTRAR'S SIGNATURE LeRoy Claypool 39
25. FUNERAL DIRECTOR'S SIGNATURE James Hennie ADDRESS 700 Jefferson

(Licensed Embalmer's Statement on Reverse Side)

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

APR 26 1950

Park.

RECEIVED
APR 19 1950
District Health Officer No. 9

District File Number

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 .....
Student Embalmer

Signed .....

Licensed Embalmer No. 3641

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.