

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 24392
7180

318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO. 1003		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Callaway</i>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St Louis mo</i>		c. LENGTH OF STAY (in this place) <i>13 days</i>		c. CITY OR TOWN <i>Guthrie</i>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>BARNES Hospital</i>				e. STREET ADDRESS (If rural, give location) <i>0170</i>				
3. NAME OF DECEASED (Type or Print) a. (First) <i>MERLE</i> b. (Middle) <i>IRENE</i> c. (Last) <i>COLTER</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>8-1-54</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>July 11 - 1906</i>		
9. AGE (In years last birthday) <i>48</i>		IF UNDER 1 YEAR Months <i>13</i>		IF UNDER 2 HRS. Hours <i></i> Min. <i></i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <i>Callaway co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <i>George Day</i>			13b. MOTHER'S MAIDEN NAME <i>Elizabeth Fisher</i>		14. NAME OF HUSBAND OR WIFE <i>Milford Colter</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Milford Colter, Guthrie, Mo.</i>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Subdural bleeding due to ruptured aneurysm</i>					INTERVAL BETWEEN ONSET AND DEATH <i>21 days</i>	
		ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>					10 days	
		DUE TO (b) <i>Heart failure</i>					13 days	
		DUE TO (c) <i>Respiratory trouble due to central stimulation</i>						
		II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <i>457x</i>				
22. I hereby certify that I attended the deceased from <i>7-18</i> , 1954, to <i>8-1</i> , 1954, that I last saw the deceased alive on <i>8-1</i> , 1954, and that death occurred at <i>7:05A</i> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>F R Muller M.D.</i>				23b. ADDRESS <i>Barnes Hospital, St. Louis, Mo</i>		23c. DATE SIGNED <i>8/1/54</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>8-1-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest</i>		24d. LOCATION (City, town, or county) (State) <i>Fulton, Mo.</i>		
DATE REC'D BY LOCAL REG. <i>AUG 2 1954</i>		REGISTRAR'S SIGNATURE <i>J Carl Smith M.D</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wallace Funeral Home Fulton, Mo.</i>				

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

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.....
Signature of Student Embalmer

Signed *Wenjel C. Browning*.....

Licensed Embalmer No. *2729*

P. O. Address *Fulton*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.