

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17697

State File No. _____

FILED JUN 12 1956

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4880

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	c. LENGTH OF STAY (In this place) <u>3 days</u>	c. CITY OR TOWN <u>St. Ann's</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>10314 Breckenridge Dr.</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Florence</u>	b. (Middle) <u>Marie</u>	c. (Last) <u>Colby</u>	(Month) <u>5</u>	(Day) <u>17</u>	(Year) <u>56</u>

5. SEX: <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/28/02</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <input type="checkbox"/> <u>Ashland, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Arthur Trenaine</u>	13b. MOTHER'S MAIDEN NAME <u>Colette Ford</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas E. Colby</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>497-01-1145</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Thomas E. Colby</u>	ADDRESS <u>10314 Breckenridge</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic vascular disease</u>		<u>3 years</u>
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>331x</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from May 6, 1953, to May 17, 1956, that I last saw the deceased alive on May 17, 1956, and that death occurred at 5:22 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. J. Newman</u>	(Degree or title) <u>M.D.</u>	23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>5-18-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5/21/56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MAY 21 1956</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Bull Campbell M.D.</u>	ADDRESS <u>Mort. 5165 Delmar Bl</u>
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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 *Dill C. Dranson*

Licensed Embalmer No. *476*

P. O. Address *St. Louis*

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.