

THE DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3842

FILED MAR 15 1957

STATE FILE NUMBER

Public Health Service

100-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 219

1. PLACE OF DEATH a. COUNTY <b>Butler</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Butler</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Poplar Bluff</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rural</b>		0120 0	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) <b>Poplar Bluff, Hosp, 8Hrs</b>			Length of stay in lb <b>8Hrs</b>	d. STREET ADDRESS <b>5 1/2 M<sub>1</sub> S.W. of Fisk</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Kenneth Dale Colter</b>				First	Middle	Last	4. DATE OF DEATH <b>2-28-57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-23-57</b>	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Year
		.WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Months	Days	Hours
					6		Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Butler, Co. Mo.</b>		12. COUNTRY OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Colter</b>				14. MOTHER'S MAIDEN NAME <b>Grace Remminga</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>James Colter.</b>		Address <b>Fisk, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Staph. Septicemia</b> DUE TO (b) <b>Impetigo</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY.	STATE
21. I attended the deceased from <b>2-28-57</b> to <b>2-28-57</b> and last saw her/him alive on <b>2-28-57</b> . Death occurred at <b>2-28-57 11:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Arthur O. Parker, M.D.</i>				22b. ADDRESS <b>Poplar Bluff, Mo.</b>		22c. DATE SIGNED <b>2/28/57</b>	
23a. BURIAL, CREMATION, REMOVED, SPOKE/2		23b. DATE <b>3-1-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Shain Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Butler, Mo.</b>		23e. STATE
24. FUNERAL DIRECTOR <i>J.C. White</i>			ADDRESS <b>Fisk, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>3/9/57</b>		26. REGISTRAR'S SIGNATURE <i>J.W. Minette</i>	

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED

MAR 11 1957

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

*not embalmed*

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision...

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F  
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.