

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037521

STATE FILE NUMBER

FILED OCT 21 1958 Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 383

1. PLACE OF DEATH a. COUNTY <b>St. Francois</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Francois</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Bonne Terre</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Farmington</b> <u>0940</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Bonne Terre Hosp.</b>		Length of stay in 1b <b>4 months</b>	d. STREET ADDRESS <b>FRD # 1</b> (If outside, give location)
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>Harriett</b>	Middle <b>Colt</b>	Last <b>Reinhart</b>	4. DATE OF DEATH	Month <b>October</b>	Day <b>14</b>	Year <b>1958</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <b>2</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1858</b>	9. AGE (In years last birthday) <b>99</b>	IF UNDER 1 YEAR	IF UNDER 24 HRS.
					Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Suspension Bridge, N. Y.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>
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13. FATHER'S NAME <b>James B. Colt.</b>	14. MOTHER'S MAIDEN NAME <b>Mary A. Morris</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>J. B. Reinhart, SR.</b> Address <b>Farmington, Missouri</b>
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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>Anteriosclerotic heart disease</b>	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>4200</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
		<b>15 yrs.</b>
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		

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.)
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **Nov 1953** to **10-14-58** and last saw her **alive** on **10-14-58**  
Death occurred at **10:45 Am** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>C. E. Carleton, M.D.</b> (Degree or title)	22b. ADDRESS <b>Farmington, Mo</b>	22c. DATE SIGNED <b>10-15-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10/16/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
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24. FUNERAL DIRECTOR <b>Miller Funeral Home</b> ADDRESS <b>Farmington, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Oct. 15, 1958</b>	26. REGISTRAR'S SIGNATURE <b>Ether Rudloff</b>
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(Licensed Embalmer's Statement on Reverse Side)

300  
1-56

Health, Welfare Public Service

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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 Paul R. Regel

Licensed Embalmer No. 412

P. O. Address Farmington

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