

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025607

STATE FILE NUMBER

FILED VS. JUL 20 1959

Registration District No. 156 Primary Registration District No. 2001 Registrar's No. 344

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Jasper</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Cherokee</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Joplin</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Galena</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. John's</u>		Length of stay in lb <u>4 hours</u>	d. STREET ADDRESS (If outside, give location) <u>1200 Mineral</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Imogene</u> Middle <u>Colbert</u> Last <u>Colbert</u>			4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1959</u>		
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/17/1916</u>	9. AGE (In years, months, days) <u>42 yrs.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Galena, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>N. C. Camp</u>		13b. MOTHER'S MAIDEN NAME <u>Susie West</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
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>513-10-7638</u>		17. INFORMANT <u>Fannie Burnett</u> Address <u>Baxter Spgs., Kan.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemorrhage Cerebral left Frontal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Rupture Left Striate Artery</u> DUE TO (c) <u>Etiology Undetermined</u> 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 <u>6 hrs</u>
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.) <u>331 X</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 <u>Jan 1948</u> to <u>July 17 1959</u> and last saw her alive on <u>7/17/59</u> Death occurred at <u>10:45 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Paul H. Grubb M.D.</u> (Degree or title)			22b. ADDRESS <u>Galena, Kansas</u>		22c. DATE SIGNED <u>7/17/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>7/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Galena, Kansas</u>
24. FUNERAL DIRECTOR <u>Lloyd Kitch</u>		ADDRESS <u>Galena, Kansas</u>		25. DATE RECD. BY LOCAL REG. <u>July 21, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Doyle Merriam</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

88 100

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 *Steve Parker*

Licensed Embalmer No. *2548*

P. O. Address *John ...*

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.