

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-031604

FILED VS AUG 31 1960

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>PIKE</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) <u>LOUISIANA</u> OR TOWN		Length of stay in 1b <u>9 DAYS</u>	c. CITY OR TOWN <u>CLARKSVILLE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) <u>PIKE COUNTY HOSPITAL</u> HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>ANN</u> Last <u>COLBERT</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>24</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-87</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

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>LINCOLN CO MO</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>SAM. FERGUSON</u>	13b. MOTHER'S MAIDEN NAME <u>ANNA POLK.</u>	14. NAME OF HUSBAND OR WIFE <u>SAM. FOSTER COLBERT</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>SAM F. COLBERT, CLARKSVILLE, MO</u> Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM.</u>		<u>9</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>NOT KNOWN</u>	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <u>8:15</u> a.m. Month, Day, Year <u>60</u>	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 8.15.60 to 8.24.60 and last saw her alive on 8.24.60
Death occurred at 4.45 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>G. P. Collier D.O.</u> (Degree or title)	22b. ADDRESS <u>Louisiana</u>	22c. DATE SIGNED <u>9.25.60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>AUG 27, 60</u>	<u>GREENWOOD CEM.</u>	<u>CLARKSVILLE, MO.</u>

24. FUNERAL DIRECTOR <u>CARROLL-COLLIER, CLARKSVILLE, MO.</u> ADDRESS	25. DATE RECD. BY LOCAL REG <u>Aug 25-1960</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ 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. (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.