MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

8040

File No. ____
Registered No. 885

1. PLACE OF DEATH
County: Jackson
Township: Kaw
City: Kansas City Mo (No. 3633 Harrison St. ____ Ward)
Registration District No. 3 9 2
Primary Registration District No. 2 9 3

2. FULL NAME: Elizabeth Collier
(a) Residence. No. 3633 Harrison St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 44 yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: John N Collier

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 7 1848

7. AGE: Years 78 | Months 2 | Days 24 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): ____
(c) Name of employer: ____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Platte County Mo

PARENTS
10. NAME OF FATHER: Buford D. Adkins
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Kentucky
12. MAIDEN NAME OF MOTHER: Margaret F Bivens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Clay County Mo

14. INFORMANT: William L Rock
(Address) 3633 Harrison

15. FILED 3/2, 19 27 M. M. Crouse
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 1 1927

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1927, to March 1, 1927, that I last saw h. alive on March 1, 1927, and that death occurred, on the date stated above, at 11 30 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho-pneumonia 1 dy
126
10 dy
9 dy (duration) ____ yrs. ____ mos. 6 ds.

CONTRIBUTORY (SECONDARY) Myocarditis Chronic with acute Nephritis (duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED: ____
IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? No. DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Phys. exam
(Signed) R. T. Sloan, M. D
3-2, 1927 (Address) Rich Hill Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Liberty Cemetery — DATE OF BURIAL: Mar 3 1927
20. UNDERTAKER: John M. Wagner — ADDRESS: 1409 Broadway

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1125 Rialto bldg
Victor 5832
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