

JAN 28 1928

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

Do not use this space.

42418

1. PLACE OF DEATH

County St. Louis
Township Carondelet
City Koch (No. Koch Hosp.)

Registration District No. 1123
Primary Registration District No. 6248 B

File No. _____
Registered No. 474 St. _____ Ward _____

2. FULL NAME

William Collins

(a) Residence, No. 2422 No. 11th St. _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred X yrs. 2 mos. 1 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED OR DIVORCED, HUSBAND OR (or) WIFE OF

Sallie Thomas Collins

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

April 15, 1875

7. AGE

YEARS 52

MONTHS 7

DAYS 25

IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Tennessee

(STATE OR COUNTRY)

10. NAME OF FATHER

Andrew Collins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Tennessee

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Caroline Jones

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Alabama

(STATE OR COUNTRY)

14.

INFORMANT R. Koch Hospital Records
(Address) Koch Missouri

15.

FILED Dec. 12 1928 L. C. Obrock M.D.
REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec. 10 1928

17.

I HEREBY CERTIFY, That I attended deceased from Sept. 29 1928, 1928, to Dec. 10 1928, 1928, that I last saw h. im alive on Dec. 10 1928, and that death occurred, on the date stated above, at 7:35 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

Unknown

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

Yes

WHAT TEST CONFIRMED DIAGNOSIS

X-Ray & Sputum

(Signed) R. H. Ehrlich

_____, M. D.

12/10/28 (Address)

Koch Hospital.

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Washington Park Cem

DATE OF BURIAL

12/15 1928

20. UNDERTAKER

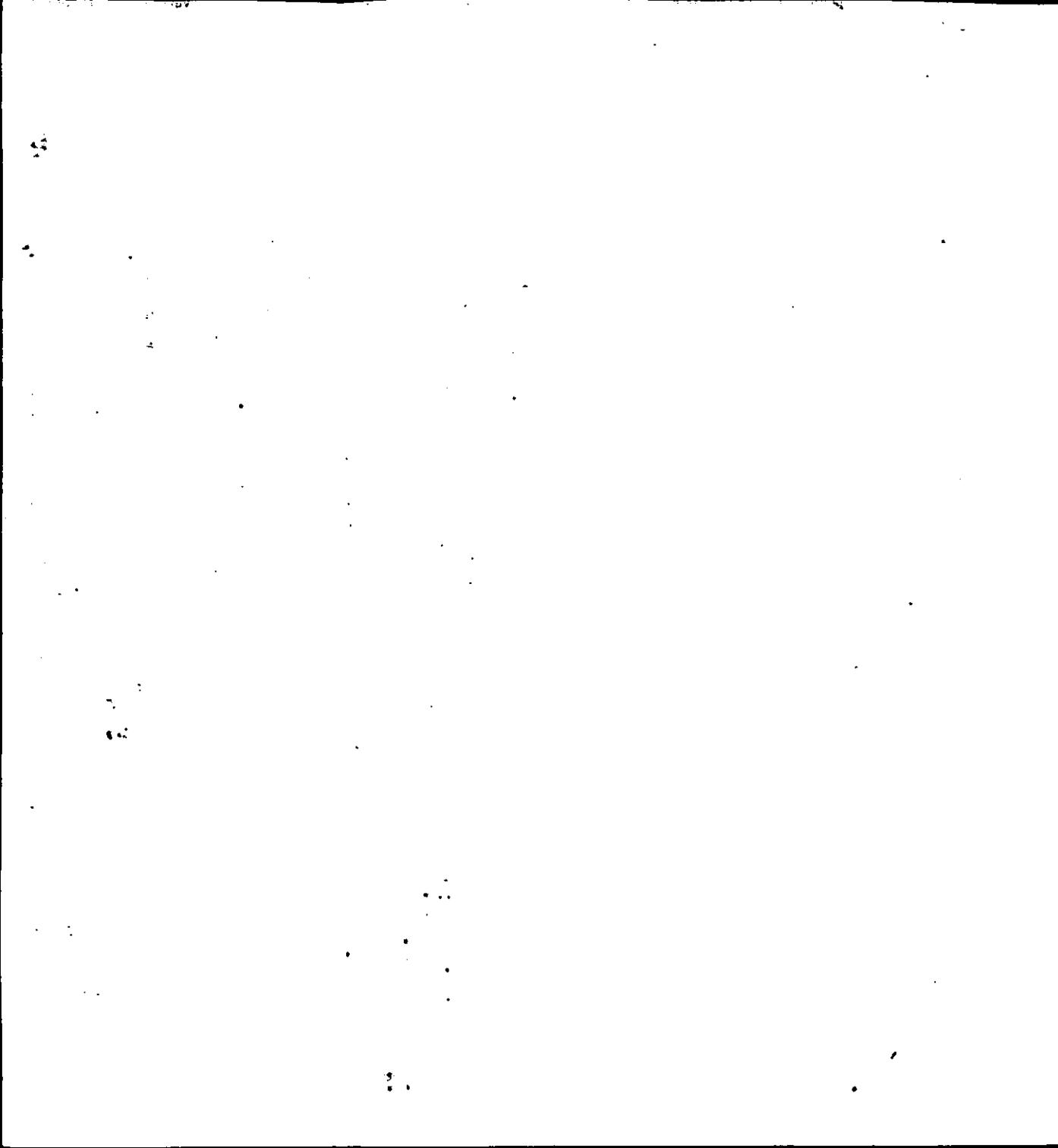
Peoples' Bur. Co

ADDRESS

3100 Franklin

Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County St. Louis Registration District No. 1123 File No.
 Township Carondelet Primary Registration District No. 6248 Registered No. 414
 City (No.) St. Ward

2. FULL NAME William Collins
 (a) Residence No. St., Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** Col **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 13 - 1875

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
53 7 23

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 10 1928

17. I HEREBY CERTIFY That I attended deceased from
 19....., 19.....
 that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.
 THE CAUSE OF DEATH WAS AS FOLLOWS:
 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. SIGNED 47 19 29 L. C. Obrack, M. D. REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

Exact statement of occupation is to property classified.

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