

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

Do not use this space.

14132

1. PLACE OF DEATH

County Jackson
Township Kaw
City Kansas City

Registration District No. 329
Primary Registration District No. 1002
(No. Trinity Lutheran Hosp.)

File No. _____
Registered No. 1641
St. _____ Ward _____

2. FULL NAME Miss May Collins

(a) Residence. No. Berkshier Hotel 1017 E. Summit St. 6 Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

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 Geo. H. Collins

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 18, 1863

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
67 10 20

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) Deeronick
(STATE OR COUNTRY) Ill.

10. NAME OF FATHER Leman Fisher

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

12. MAIDEN NAME OF MOTHER Not Known

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

14. INFORMANT Mrs Fern Pflergrat
(Address) 216 Pine, Arkansas City, Kan.

15. FILED 4/8 1931 M. M. Crowe REGISTRAR
Assr

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 7, 1931

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1931, to 7 - April, 1931, that I last saw him alive on 7, 1931, and that death occurred, on the date stated above, at 9:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
acute nephritis
130 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) unknown (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? yes

WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) D. H. Hickok, M. D.

*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 Wellington Kansas DATE OF BURIAL 4/8 1931

20. UNDERTAKER J. W. Wagner ADDRESS 204 W. Leonard

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.

WHITE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

Mr Huskock

Realty Bldg