

JAN 25 1938

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

Do not use this space.

1. PLACE OF DEATH

102 County Shelby
Township Salt River
City Shelbina (No.)

Registration District No. 830
Primary Registration District No. 6071

File No. 46917
Registered No. 53
St. Ward)

2. FULL NAME Lula May 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. 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) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 29, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
79 5 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hannibal Missouri

13. NAME Samuel Hayfer

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

15. MAIDEN NAME Margaret Mayes

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dont Know

17. INFORMANT (ADDRESS) R. J. ...

18. BURIAL, CREMATION, OR REMOVAL PLACE Bacon Chapel DATE Dec 15, 1937

19. UNDERTAKER (ADDRESS) Hayes Shelbina Mo

20. FILED Dec 31, 1937 Ruth Jaynes Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-14-1937

22. I HEREBY CERTIFY, That I attended deceased from 4-6-33 19... to 11-20-37 19...
I last saw her alive on 11-20-37 19... Death is said to have occurred on the date stated above, at 7.2 a.m.

The principal cause of death and related causes of importance were as follows:

Paralysis Left Side 12-10-37

Other contributory causes of importance:

Hypertension
Senile dementia 1933

Name of operation Date of...
What test confirmed diagnosis? Chemical Was there an autopsy? no.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify (Signed) A. M. Wood M. D. (Address) Shelbina

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

825

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

46917
Do not use this space.

1. PLACE OF DEATH
 (a) County Shelby Registration District No. 8307
 (b) Township Salt River Primary Registration District No. 6091 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
2. PRINT FULL NAME Lula May Collins
 (a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid
- 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
- | 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|--------|-----------|----------|-----------|--|
| | <u>79</u> | <u>3</u> | <u>15</u> | |
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- FATHER
 13. NAME
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
- MOTHER
 15. MAIDEN NAME
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)
17. INFORMANT (ADDRESS)
18. BURIAL, CREMATION, OR REMOVAL
 PLACE DATE 19
19. FUNERAL DIRECTOR (ADDRESS)
20. FILED 19.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-14-1937
22. I HEREBY CERTIFY, That I attended deceased from to 19.....
 I last saw h. alive on 19..... Death is said to have occurred on the date stated above, at m.
 The principal cause of death and related causes of importance were as follows:
Paralysis left side
Cerebral Hemorrhage
a. m. m. 12-10-37
 Date of onset
- Other contributory causes of importance:
826
- Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy?
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
- Manner of injury
 Nature of injury
24. Was disease or injury in any way related to occupation of deceased?
 If so, specify
 (Signed) A. M. Wood , M. D.
 (Address) Shelby Mo

Local Registrar.

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTAL

