

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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

16458  
Do not use this space.

JUN 12 1939

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. .... Registered No. **3992**  
(c) City St. Louis Mo. (d) Street No. St. Anthony's Hospital ..... 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 16 yrs. 6 mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

<sup>452</sup>  
Name: Ola V. Collins  
(a) Residence, No. 4119 Osceola St. St. 15 (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 F. 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 21-1887

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
51 6 8

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife  
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) April 15 1939 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Texas

FATHER  
13. NAME Unknown

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

MOTHER  
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS) Mrs. Ace K. Frey Mack  
4123 Osceola

18. BURIAL, CREMATION, OR REMOVAL PLACE Bellefontaine DATE May-1 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Oscar J. Hoffmeister  
4016 Cheppewa St.

20. FILED MAY 1 1939 J. B. Budick  
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 29th 1939

22. I HEREBY CERTIFY, That I attended deceased from June 2nd 1936 to April 29th 1939.  
I last saw her alive on April 29th 1939. Death is said to have occurred on the date stated above, at 7 P. m.  
The principal cause of death and related causes of importance were as follows:

Acute Cardiac Failure  
Chronic Cardiac Valvular Disease (Mitral Regurgitation)  
Nephritis, Chronic  
Date of onset 4/27/39

Other contributory causes of importance:  
None  
Name of operation None Date of .....  
What test confirmed diagnosis? Clinical 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? No.  
If so, specify Diabetes Mellitus  
(Signed) [Signature] M. D.  
(Address) 3606 Travis - St. Louis, Mo.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Howard P. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St Louis Mo*

**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 this body is not embalmed, above space should be left blank.**