

STANDARD CERTIFICATE OF DEATH

State File No. 34124
Registrar's No. 8662

NOV 13 1939

791
1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St Louis Mo
(b) City or town 4720 Ashland Ave
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4720 Ashland Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Florence Mgt Collins
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11-30-1915
(Month) (Day) (Year)

8. AGE: Years 23 Months 10 Days 9 If less than one day hr. _____ min. _____

9. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Nurse

11. Industry or business Hospital

12. Name John M Collins

13. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

14. Maiden name Nellie Fagan

15. Birthplace St Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature John M Collins
(b) Address 4720 Ashland

17. (a) Burial (b) Date thereof 10-12-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Catholic

18. (a) Signature of funeral director Bullivich
(b) Address 2849 No Euclid Ave

19. (a) OCT 10 1939 (b) J F Bruch
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Louis
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. 4720 Ashland (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 9 year 1939 hour 8 minute 30 P M.
21. I hereby certify that I attended the deceased from 10-2-39 to 10-9-39, 19____; that I last saw her alive on 10-9-39, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia Tuberculin Duration 3 yrs

Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) None

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Charles P. Hunsaker M. D. or other _____
Address 607 No Grand Blvd Date signed 10/10/39

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.

Dr. A.C. Henske
dan Club Belg

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 3077
Henry C. Kimesi, Registered Apprentice No. 170
working under my personal supervision.

Signed Al Mayfield
Licensed Embalmer No. 3077
P. O. Address _____

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.