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11-10-39
5-17-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED MAR 14 1940

STANDARD CERTIFICATE OF DEATH

State File No. 6245

Registration District No. 156

Primary Registration District No. 4090

Registrar's No. 14

1. PLACE OF DEATH: Cass

(a) County Cass

(b) City or town Harrisonville Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution 101 North Lexington 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community 20 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass

(c) City or town Harrisonville
(If outside city or town limits, write "RURAL")

(d) Street No. 0 North Lexington
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John D. Collins 452

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex ma 5. Color or race wh 6. (a) Single, widowed, married, divorced si

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 3 4 1871
(Month) (Day) (Year)

8. AGE: Years 66 Months 11 Days 16 If less than one day hr. _____ min. _____

9. Birthplace Clay County Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation laborer

11. Industry or business _____

MOTHER FATHER { 12. Name Jackeriah Collins

13. Birthplace Clay Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Melgroves

15. Birthplace Clay Co Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Oliver L. Collins

(b) Address 101 No. Lexington

17. (a) Burial (b) Date thereof 2 22 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial, Crest Cem

18. (a) Signature of funeral director Arthur Brown

(b) Address Harrisonville Mo. 245

19. (a) 2-22-40 (b) Frederick M. S.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20
year 1940 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb 20
1940 to Feb 20 1940
that I last saw him alive on Feb 20 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature J. L. Scott (M. D. or other) 1

Address Harrisonville Mo Date signed 2/24/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

19
80

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

Floyd Atkinson

Licensed Embalmer No.

3920

P. O. Address

Harrisonville 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6245
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 156

Primary Registration District No. 4090

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME

John D. Collins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

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 _____ year

7. Birth date of deceased _____

3
(Month)

4
(Day)

1871
(Year)

8. AGE:

Years

Months

Days

If less than one day _____ hr. _____ min.

68 total

11

16

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____

(Burial, cremation, or removal)

(b) Date thereof _____

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-22-40

(Date received local registrar)

(b) [Signature]

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

20. DATE OF DEATH: Month Feb day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

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(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 [Signature] (M. D. or other) _____

Address Harrisonville State signed Mo

SUPPLEMENTAL

1775

1776

1777

1778

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1780

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