

No. 2
-10-39
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13838

MAY 15 1940
Registration District No. 399

State File No. _____
Registrar's No. 1550

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 10 Yrs.
years, months or days

8. (a) PRINT FULL NAME Willard O. COLLYER. 460

3. (b) If veteran, No No name war
3. (c) Social Security No. No

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Lina Collyer
6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased December 26th 1873
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 3 12 hr. min.

9. Birthplace Butler County Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business Oil Fields

12. Name James Wesley Collyer.

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mrs. Sarah Hughes

15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Lina Collyer.
(b) Address 2103 East 35th Street.

17. (a) Burial (b) Date thereof 4/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenlawn Cemetery

18. (a) Signature of funeral director Melody McGilley.
(b) Address K. C. Mo.

19. (a) Apr. 10, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2103 East 35th Street.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 8
year 1940 hour 1 minute 40 P.M.

21. I hereby certify that I attended the deceased from Apr 7, 1940, to Apr 8, 1940,
that I last saw him alive on April 8, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to 9/4/40

Due to _____

Other conditions (Include pregnancy within 3 months of death)
Acute Pulmonary Embolism

Major findings: _____
Of operations _____

Of autopsy Coronary thrombosis

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?

White at work? _____ (Specify type of place)
(e) Means of injury! Arterial Thrombosis
Address 218 W. 11th St. Date signed 4/10/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Licensed Embalmer No.

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.