

S. No. 2
-11-10-39
5-17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27927

State File No.

FILED SEP 16 1940

Registration District No.

Primary Registration District No. 3006

Registrar's No. 188

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

1. PLACE OF DEATH: Boone
(a) County Boone
(b) City or town Columbia
(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution No (Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME John Calvin Collins
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Emma Jane Young
6. (c) Age of husband or wife if alive 7 years
7. Birth date of deceased March 8 1860 (Month) (Day) (Year)

8. AGE: Years 80 Months 5 Days 16 If less than one day hr. min.

9. Birthplace Greene Co. Illinois (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER { 12. Name Benjamin W Collins
13. Birthplace Ohio (City, town, or county) (State or foreign country)
14. Maiden name Isabella Collins
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Jean Collins
(b) Address Columbia Mo 84

17. (a) Burial (b) Date thereof Aug 26-1940 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Tenn

18. (a) Signature of funeral director R. O. Wilson
(b) Address

19. (a) 8/26/40 (b) Allie Selby (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Columbia Rural (If outside city or town limits: write "RURAL")
(d) Street No. Route 4 (If rural, give location)
(e) If foreign born, how long in U. S. A. L years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24th year 1940 hour 6:45 minute P. M.

21. I hereby certify that I attended the deceased from Aug 29th 1940 to Aug 24, 1940; that I last saw him alive on Aug 29, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy

Due to Generalized arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death) 420

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? 74 (Specify type of place)

While at work? (a) Means of injury

23. Signature James M. Carter (M. D. or other) M.D.
Address Columbia, Mo Date signed 8-26-40

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: *Rowland*

Licensed Embalmer No. *3183*

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.