

FILED OCT 18 1940

STANDARD CERTIFICATE OF DEATH

State File No. 32355

Registration District No. 434

Primary Registration District No. 569A

Registrar's No. 118

1. PLACE OF DEATH:

(a) County JOHNSON
 (b) City or town WARREN, MISSOURI, RURAL
 (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 2
 (Specify whether
 In this community 62 YEARS
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JOHNSON
 (c) City or town RURAL
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 18
 year 1940 hour 1 minute 10 P.M.
 21. I hereby certify that I attended the deceased from July 12 40
 _____, 19 _____, to Sept 18, 1940
 that I last saw him alive on Sept 18, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death
Carcinoma Liver and Gall bladder
 Duration 1 Year

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?

99!
 (Specify type of place) _____
 While at work _____ (e) Means of injury _____
 23. Signature S. P. Johnston (M. D. or other) _____
 Address Concordia Mo Date signed 7-18-40

3. (a) PRINT FULL NAME FOX COLLINS

3. (b) If veteran, name war NO 3. (c) Social Security No. 140

4. Sex MALE 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife LOLA COLLINS 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased MAY 6 1878
 (Month) (Day) (Year)

8. AGE: Years 62 Months 4 Days 12 If less than one day _____ hr. _____ min.

9. Birthplace JOHNSON COUNTY MO
 (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

12. Name ROBERT COLLINS

13. Birthplace VIRGINIA STATE USA
 (City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

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

16. (a) Informant SAM COLLINS
 (b) Address CONCORDIA, MO.

17. (a) BURIAL (b) Date thereof SEPT 20 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MOUNT OLIVE

18. (a) Signature of funeral director E. S. JAMES

(b) Address CONCORDIA, MO

19. (a) Sept 19, 1940 (b) Lelah Anson, Dep.
 (Date received local registrar) (Registrar's signature)

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

46
AUG 27 1941

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed: 10-9-40

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.....

me

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

E. S. James

Licensed Embalmer No. *2058*

P. O. Address *Concordia 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. **32355**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **431**

Primary Registration District No. **5591**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Johnson**
(b) City or town **Harzel Hill**
(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 **Fox Collins**

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

4. Sex **m** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **m**

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

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years **62** Months **4** Days **12** If less than one day _____ hr _____ min

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) _____ (b) Date thereof: _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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 **Sept** day **18**
year **1970** 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: **Carcinoma of bladder**

Due to: **Cancer of the bladder**
Due to: **If you are anyone like this and will tell me the cause of cancer I'll be glad to write it on all death certificates. Honestly I do not know the cause of cancer this one was a primary**

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

Major findings: Of opinion _____ Underline the cause of death which 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 **E. L. Johnston** (M. D. or other) _____
Address **Concordia Mo** Date signed _____

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

ROWENA MOORE

SUPPLEMENTARY

