

No. 2
-11-10-39
5-17-39
1

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37976**

DEC 16 1940

Registration District No. 1

Primary Registration District No. 1

Registrar's No. 269

1. PLACE OF DEATH

(a) County Madair
(b) City or town Kimberville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Grinn B. Smith
(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

8. (a) PRINT FULL NAME Henry E. Collins

3. (b) If veteran, name was none 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife none 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec 21 1925
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>16</u>	<u>10</u>	<u>26</u>	hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business none

MOTHER FATHER

12. Name Walter Collins
13. Birthplace Putnam Co MO
(City, town, or county) (State or foreign country)
14. Maiden name Anna May Adams
15. Birthplace Shubert Co MO
(City, town, or county) (State or foreign country)

16. (a) Informant John D. Collins

(b) Address Warthington Mo. R. 1

17. (a) Burial (b) Date thereof 11-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Pleasant Home

18. (a) Signature of funeral director Wm N West

(b) Address Independence MO

19. (a) Nov. 1940 (b) Spencer L. Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Putnam
(c) City or town Warthington
(If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 17
year 1940 hour 3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 11-16-1940
to 11-17, 19 40
that I last saw him alive on 11-17, 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure
Symptoms of meningitis (epidemic)

Due to Generalized streptococcal peritonitis

Due to acute appendicitis
(appendix not ruptured)

Other conditions 12/1
(Include pregnancy within 3 months of death)

Major findings: Violent type of Streptococcal Peritonitis with appendicitis
Of autopsy _____

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 George E. Grinn (M. D. or other) MD
Address 102 E. Randolph St Date signed 11-17-40

Duration
<u>2-4 hrs</u>
<u>1-2 hrs</u>
<u>24 hrs</u>
<u>36 hrs</u>

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 12-40-2333

Date Filed DEC 14 1940

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 my

help, Registered Apprentice No. _____

working under my personal supervision.

Signed Wm H West

Licensed Embalmer No. 2882

P. O. Address Queens City Me

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.