

REC FEB 14 1941

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2530  
Do not use this space.

1. PLACE OF DEATH

(a) County FRANKLIN Registration District No. 294  
(b) Township CENTRAL Primary Registration District No. 548413  
(c) City or \_\_\_\_\_ (d) Street No. 1 St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ROSE COLLINS

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF WM. COLLINS  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCT. 4 1874  
7. AGE YEARS 66 MONTHS 3 DAYS 22 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union, MO.

13. NAME \_\_\_\_\_  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT WM. COLLINS  
(ADDRESS) ST. CLAIR, MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE TOOF - ST. CLAIR DATE JAN. 28, 1941

19. FUNERAL DIRECTOR (NAME) CASEY & LENOX  
(ADDRESS) ST. CLAIR, MO.

20. FILED Feb 8, 1941 T. A. Duckworth  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan - 26 41  
22. I HEREBY CERTIFY That I attended deceased from 3-16-1940 to Jan - 26 41  
I last saw her alive on Nov 9 - 1940, 1940 Death is said to have occurred on the date stated above, at 11:00 a.m.  
The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis  
from  
Other contributory causes of importance: 131a

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) W. E. Ketchell M. D.  
(Address) St. Clair, Mo.

WHILE PLAINLY, WITH UNFADING RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

---

---

**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 *K. M. L...*

Licensed Embalmer No. *360*

P. O. Address *St. Clair, 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.**

No. 2B  
2-21-40  
VI X22859

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2530

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 294

Primary Registration District No. 5409B

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Franklin

(b) City or town Central T.P.  
(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Rose Collins

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

4. Sex 7 5. Color or race W 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 66 Months 3 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 3/27/41 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lewis

(c) City or town St. Clair - 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.

20. DATE OF DEATH: Month Jan day 26  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ 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:

(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) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

While at work? \_\_\_\_\_

23. Signature H. E. Kitchell (M. D. or other) \_\_\_\_\_  
Address St. Clair Mo Date signed \_\_\_\_\_

SUPPLEMENTARY

