

JAN 25 1941

Registration District No. 298

Primary Registration District No. 3019

Registrar's No. 8

1. PLACE OF DEATH:

(a) County JACKSON - Co.
(b) City or town INDEPENDENCE, MO.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
511 - W. MILL ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community ABOUT 17 YRS.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town INDEPENDENCE, MO.
(If outside city or town limits, write "RURAL")
(d) Street No. 511 - W. MILL ST.
(If rural, give location) 0
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John Rollins

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

4. Sex Male 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Luella Rollins 6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased July 4 - 1884
(Month) (Day) (Year)

8. AGE: ✓ Years 57 Months 6 mo. Days 1 da. If less than one day hr. _____ min. _____

9. Birthplace COLUMBIA, MO. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business _____

MOTHER FATHER
12. Name HARRISON ROLLINS
13. Birthplace COLUMBIA, MO. (1)
(City, town, or county) (State or foreign country)
14. Maiden name JUDY CLARK
15. Birthplace COLUMBIA, MO. (1)
(City, town, or county) (State or foreign country)

16. (a) Informant Luella Rollins

(b) Address 511 - W. - MILL ST.

17. (a) BURIAL (b) Date thereof JAN. - 9 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation WOODLAWN CEM.

18. (a) Signature of funeral director E. E. Davis

(b) Address 312 - E - LEXINGTON

19. (a) Jan 8 1941 (b) J. L. Cook M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 5
year 1941 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from Jan 3
1941 to Jan 5 1941
that I last saw him alive on Jan 5
and that death occurred on the 5th and hour stated above.

Immediate cause of death Peritonitis

Due to Acute Colitis N

Due to _____ N

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

Major findings:
Of operations _____

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?
310

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. H. Laurie (M. D. or other) 11

Address Independence, Mo Date signed 1-10-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

18
4
H

5

STATE OF TEXAS
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
EMBALMERS' BOARD

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 *Henry C. Lee*
Licensed Embalmer No. *4199*

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, fact should be so stated above.

Registration District No. 398

Primary Registration District No. 3019

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(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 John Rollins

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 _____ years

7. Birth date of deceased July 4

(Month)

(Day)

1884 (Year)

8. AGE:

Years

Months

Days

If less than one day

56

6

1

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-1-41

(Date received local registrar)

(b) J. L. Cook M.D.

(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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Jan day 5

year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____

19 _____ to _____ 19 _____

that last saw him 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 _____

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 W. H. Laurie

(M. D. or other)

Address Independence

Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

73