No. 2
4-13

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1942

Registration District No. 398

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5554

State File No. 6823

Registrar's No. 38

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

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Atherton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Blue Twp. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... In this community: 35 years (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME: GEORGE A COLLIER
3. (b) If veteran, name war: None
3. (c) Social Security No.: None

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married or divorced: Married
6. (b) Name of husband or wife: Lucy Collier
6. (c) Age of husband or wife if alive: 55 years
7. Birth date of deceased: Aug. 22 1879 (Month) (Day) (Year)

8. AGE: Years 62 Months 5 Days 6 If less than one day ..... hr. ..... min.

9. Birthplace: Columbia Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Life Mason
11. Industry or business: River Construction work

FATHER
12. Name: George L. Collier
13. Birthplace: Unknown Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Maggie Rollins
15. Birthplace: Columbia Mo (City, town, or county) (State or foreign country)

16. (a) Informant: Lucy Collier
(b) Address: Atherton Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/1/42 (Month) (Day) (Year)
(c) Place: burial or cremation: Salem Cem.
18. (a) Signature of funeral director: George Robinson
(b) Address: Independence Mo
19. (a) 1-31-1942 (Date received local registrar) (b) James W. Ross (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30 year 1942 hour 2 minute 35 P. M.
21. I hereby certify that I attended the deceased from July 20, 1941, to Jan 30, 1942, that I last saw him alive on Jan 30 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Hypostatic pneumonia — Duration
Due to: Myocardial degeneration
Due to: Hypertension
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: L. W. Higgins (M.D. or other) D.O.
Address: Buckner Mo Date signed 1/31/42

1163 (Licensed Embalmer's Statement on Reverse Side)

Dr. Higgins
Buckner, Mo - Hop -

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: Floyd L. Carson

Licensed Embalmer No. H199

P. O. Address: Independence, 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, fact should be so stated above.

7-S. No. 2B
0M—8-21-41
I X29288

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BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6823

Registration District No. 398 Primary Registration District No. 5554 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Atherton
(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 years, months or days)
In this community

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME George R. Collier
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
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 Years
7. Birth date of deceased Aug (Month) 22 (Day) 18 (Year)

8. AGE: Years 62 Months 5 Days 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 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	Duration
Hypostatic Pneumonia (Lobar)	
Due to Myocardial Degeneration	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature L. W. Higgins (M.D. or other) M.D.
Address Buckner Mo Date signed 4/4/42

SUPPLEMENTARY

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