

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

15857

Do not use this space.

APR 16 1948
1. PLACE OF DEATH
(a) County Shannon Registration District No. 351
(b) Township Annate Sub Primary Registration District No. 4112
(c) City Winona, Mo. (d) Street No. _____ St.
(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 Thomas Martin Collins
(a) Residence, No. Winona, Mo. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Miss Leland of Caroline Collins
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 28 - 1879
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 9 14
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
10. Date deceased last worked at this occupation (month and year) Aug 1943 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas
13. NAME Ben Collins
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No data
15. MAIDEN NAME Lydia Jones
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No data
17. INFORMANT (ADDRESS) Nelaud Bellies Winona, Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Howell Co. Collins Ave DATE 3-18-1948
19. FUNERAL DIRECTOR (NAME) (ADDRESS) John Duncanson Mt View, Mo
20. FILED 3-26-1948 Frank Byde M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-17-1948
22. I HEREBY CERTIFY, That I attended deceased from 1-21-1948 to 3-15-1948
I last saw him alive on 3-14-1948. Death is said to have occurred on the date stated above, at 2-2 m.
The principal cause of death and related causes of importance were as follows:
Myocarditis
Date of onset Aug 48
Other contributory causes of importance: 93rd
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. T. Candy, M. D.
(Address) Greenwood, Mo.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT 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.

RECEIVED

District Health Officer No 5,

District File Number 443256

Date Filed 7-14-43

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.....

Licensed Embalmer No.....

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, above space should be left blank.