

FILED OCT 22 1943 **318**

Registration District No. **318** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Deaconess Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution. **2 days** (Specify whether

In this community.....
 years, months or days)

3. (a) PRINT FULL NAME **Lisle L. Collins**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **Lucille Orthwein Collins** 6. (c) Age of husband or wife if alive **41** years

7. Birth date of deceased **April 16 1893**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	50	5	28	hr. min.

9. Birthplace **Bethel Mo.**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Physician**

11. Industry or business

MOTHER FATHER

12. Name **A. Collins**

13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

14. Maiden name **Alice Moffitt**

15. Birthplace **Bethel Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lisle L. Collins**

(b) Address **460 Fairview, Webster Groves**

17. (a) **Burial** (b) Date thereof **10/16/43**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine Cem.**

18. (a) Signature of funeral director **Wagoner Und. Co.**

(b) Address **3621 Olive St.**

19. (a) **OCT 16 1943** (b) **J. J. Break**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **96**
 (c) City or town **Webster Groves**
 (If outside city or town limits, write "RURAL") **7**
 (d) Street No. **460 Fairview Ave.**
 (If rural, give location) **4 N.R.**
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **1**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **14**th
 year **1943** hour **1:00** minute **P.M.**

21. I hereby certify that I attended the deceased from **Oct 12**
 to **Oct 14** 19**43**
 that I last saw him alive on **Oct 12 (10 P.M.)** 19**43**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary disease. Thrombosis - Embolism 36 hrs.**

Due to.....

Due to.....

Other conditions **Hypertension**
 (Include pregnancy within months of death)

Major findings: **OK**
 Of operations.....

Of autopsy **r**

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 **D**

23. Signature **J. J. Break** (M. D. or other) **MD**

Address **4500 Olive** Date signed **10-16-43**

JAN 10 1955

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 *Neville B. Frohwitter*.....

Licensed Embalmer No. 3696.....

P. O. Address 3621 Olive St......

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.