

FILED JAN 10 1944

Registration District No. 274

Primary Registration District No. 5932

1. PLACE OF DEATH:

(a) County Pettis

(b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: LaMonte Rural Route (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 1 Year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pettis

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. LaMonte Rural Route (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Ellen Collins

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

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1875 years

7. Birth date of deceased Do not know 1875 (Month) (Day) (Year)

8. AGE: Years 68 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired

11. Industry or business Nurse

MOTHER FATHER

12. Name Pat Collins

13. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

14. Maiden name Mary Sullivan

15. Birthplace Ireland 4 (City, town, or county) (State or foreign country)

16. (a) Informant P.E. Sullivan

(b) Address Sedalia Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 3 1943 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia Mo.

19. (a) 12-3-43 (Data received local registrar) (b) Mrs Anna Berger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 1st year 1943 hour 9.15 Pm minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from over 15 years 19 \_\_\_\_\_ to 19 \_\_\_\_\_ that I last saw her alive on Nov 30 19 43 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Latent Tumor over 15 years

Other conditions None (include pregnancy within 3 months of death)

Major findings: None Of operations None Of autopsy None

Duration 48 hours

PHYSICIAN None 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) None

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

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

23. Signature J. O. B. ... (M. D. or other)

Address Sedalia Mo. Date signed 12-3-43

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

RECEIVED

District Health Officer No. 8,

File Number

Date Filed

1-7-44

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address Sedalia 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.