

FILED JUN 12 1944

Registration District No. **173**

Primary Registration District No. **5430**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Franklin**
(b) City or town **St. Clair Mo**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Central Hosp**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **65 yrs** years, months or days

3. (a) PRINT FULL NAME **William 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 **Widowed**
6. (b) Name of husband or wife **Wm Collins** 6. (c) Age of husband or wife if alive **years**
7. Birth date of deceased **3-18-72** (Month) (Day) (Year)

8. AGE: Years **72** Months **2** Days **12** If less than one day hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **John Collins**
13. Birthplace **Unknown 9** (City, town, or county) (State or foreign country)
14. Maiden name **Melba Allen**
15. Birthplace **Union Mo** (City, town, or county) (State or foreign country)

16. (a) Informant **Alta Crumb**

(b) Address **St. Clair Mo**

17. (a) **Funeral** (Burial, cremation, or removal) (b) Date thereof **5-15-44** (Month) (Day) (Year)

(c) Place: burial or cremation **St. Clair Mo**

18. (a) Signature of funeral director **Wm Collins**

(b) Address **St. Clair Mo**

19. (a) **5/19/1944** (Date received local registrar) (b) **Wm Collins** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Franklin**
(c) City or town **St. Clair Rural** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **15th** day **May** year **1944** hour **6:30** minute **PM**

21. I hereby certify that I attended the deceased from _____, 19____, 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 **Found dead on back porch of his home** Duration _____

Due to **Coronary Thrombosis**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **94a**

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? _____

While at work _____ (Specify type of place) Means of injury **Coronary**

23. Signature **Wm Collins** (Physician's signature)

Address **St. Clair Mo** Date signed **5-15-44**

RECEIVED

District Health Officer No.

District File Number.....

Date Filed 6-9-44

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.