

FILED MAY 19 1944

Registration District No. 150

Primary Registration District No. 5572

Registrar's No. 47

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Rural Prairie  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Jackson County E. Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 1/2 months  
In this community 19 years  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Independence  
(If outside city or town limits, write "RURAL")  
(d) Street No. R# 2 Box 392  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Florence Collins

3. (b) If veteran, name war No 3. (c) Social Security No. 54

4. Sex Female 5. Color or race Wh. 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive, years 37  
7. Birth date of deceased March 3rd 1858  
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Raytown Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laundry

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Joseph A. Collins  
13. Birthplace Raytown Miss.  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret De Busk  
15. Birthplace No Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. DANIEL GALVIN

(b) Address R# 2 Independence Mo

17. (a) Burial (b) Date thereof 4-19-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wood Lawn Cem

18. (a) Signature of funeral director W. C. Carson

(b) Address Independence Mo

19. (a) April 18, 1944 (b) A. H. Schelley  
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17th  
year 1944 hour 2 minute 15 P. M.

21. I hereby certify that I attended the deceased from Feb. 7th 1944, 19\_\_\_\_, to 4-17-44, 19\_\_\_\_.  
that I last saw her alive on 4-16-44, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis Duration ?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 93d

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) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) MD

Address [Address] Date signed 4-18-44

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

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**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.....

*George C. Carson*

Licensed Embalmer No.....

*2249*

P. O. Address.....

*Independence*

**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.**