

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 156

156

FILED JAN 25 1945

Registration District No. 818

Primary Registration District No. 100

Registrar's No. 456

1. PLACE OF DEATH:

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 4 days
In this community 5 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County bari 17
(c) City or town St Louis
(If outside city or town limits, write "RURAL") 219
(d) Street No. 2220 R Franklin
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Annie Collins

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

4. Sex Female 5. Color or race C. Colort
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife James Collins
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased 11 10 1893
(Month) (Day) (Year)

8. AGE: Years 51 Months 2 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace Senobia MISSI
(City, town, or county) (State or foreign country)

10. Usual occupation Harmon

11. Industry or business _____

MOTHER FATHER
12. Name Herit Sneed
13. Birthplace S. Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Alexandra Porter
15. Birthplace Missi
(City, town, or county) (State or foreign country)

16. (a) Informant James Sneed
(b) Address Senobia MISS

17. (a) Burial (b) Date thereof Jan 17 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington park Cemetery
18. (a) Signature of funeral director More Vasser

(b) Address 2812 Cass Ave, St Louis Mo.

19. (a) JAN 16 1945 J. H. Brudeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11
year 1945 hour 8 minute 15 AM.

21. I hereby certify that I attended the deceased from January 7, 1945 to January 11, 1945
that I last saw her alive on January 11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Unknown

Due to _____

Due to _____

Other conditions See
(Include pregnancy within 3 months of death)

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 Alva Moore (M.D. or other) 0

Address 2601 N. Pittier Date signed 1-15-45

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

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 L. Howell.....

Licensed Embalmer No. 2452.....

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, fact should be so stated above.