No. 2
5-43
17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1945

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

State File No. 3734

Registration District No. 337 Primary Registration District No. 4491 Registrar's No. 7

**1. PLACE OF DEATH:**
(a) County: Shelby
(b) City or town: Clarence (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 (Specify whether years, months or days)
In this community: 1½ yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Mo (b) County: Shelby 103
(c) City or town: Clarence Mo (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: U

3. (a) PRINT FULL NAME: Elizabeth Estelle Collins
3. (b) If veteran, name war: ✓
3. (c) Social Security No.: ✓
4. Sex: Fe
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Eldorado Collins
6. (c) Age of husband or wife if alive: 76 years
7. Birth date of deceased: March (Month) 4 (Day) 1868 (Year)

8. AGE: Years 76 Months 10 Days 22 If less than one day hr. min.

9. Birthplace (City, town, or county) ILL. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Andrew Jackson Chambers
13. Birthplace (City, town, or county) Ohio (State or foreign country)
MOTHER 14. Maiden name: Phoebe Wyman
15. Birthplace (City, town, or county) Minn (State or foreign country)
16. (a) Informant: Alva Collins
(b) Address: Clarence Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-1-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Maplewood Clarence
18. (a) Signature of funeral director: E. E. Hopper
(b) Address: Clarence Mo
19. (a) Feb. 5-45 (Date received local registrar) (b) Mauge Good (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan day 29 year 1945 hour 12 minute 45 P.M.
21. I hereby certify that I attended the deceased from Aug 5 1943 to Jan 29 1945 that I last saw alive on Jan 29 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Chronic myocarditis | 1 yr |
| Due to | |
| Due to | |
| Other conditions (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? (Specify type of place)
While at work? (e) Means of injury
23. Signature: D. L. Harlan M.D. (M.D. or other)
Address: Clarence Mo Date signed 2-2-45

1095

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-45-337
Date Filed FEB 11 1945

**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 Louis E. Hoppe

Licensed Embalmer No. 4761

P. O. Address Clarence 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.**