

No. 2
-5-43
-17-39
X36671

FILED OCT 8 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4087

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 1/2 Mo (Specify whether years, months or days)

In this community All his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Francis Grover Collins

3. (b) If veteran, name war No

3. (c) Social Security No. 702-18-0283

4. Sex Male 5. Color or race Wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Faye Cartwright

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased 10/15/1904
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

41	11	11	
			hr. min.

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

10. Usual occupation Switchman

11. Industry or business M O P Ry

MOTHER, FATHER

12. Name John Collins

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

14. Maiden name Katherine O Neal

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

16. (a) Informant Mrs. Katherine Collins

(b) Address 720 Kensington

17. (a) Burial (b) Date thereof 9/27/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director John P. Sheil

(b) Address K. C. Mo

19. (a) 9-27-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 419 No Topping
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26
year 1946 hour 6 minute 25 P. M.

21. I hereby certify that I attended the deceased from 4-10, 1946, to 9-25-46, 1946; that I last saw him alive on September 26, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Cachexia

Due to Metastatic Carcinoma 10 months

Due to Carcinoma of Stomach 3 1/2 yrs

Other conditions 46 d

Major findings: Carcinoma of stomach

Of operations Metastatic Carcinoma

Of autopsy adrenal & abdominal veins

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)

(c) Means of injury _____

23. Signature J. C. Castle (M. D. _____)

Address 1002 Maple Date signed 9-27-46

Argyle Bldg., after 2 P M

Dr. Cassie

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..... *John P. Shiel*

Licensed Embalmer No. *3625*

P. O. Address *C. C. No.*

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.