

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U.S. GOVERNMENT PRINTING OFFICE: 1946
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31642

FILED SEP 16 1946
SEP 31 1946

State File No. _____
7648
Registrar's No. 7679

Registration District No. _____ Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Missouri.
(b) City or town St. Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starbuck
(If not in hospital or institution, write street number or location) Memorial
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3538 VISTA AV.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME THERESE COLLINS
(b) If veteran, name war NO
(c) Social Security No. NO

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 3rd
year 1946 hour 4:30 minute _____ P. M.
21. I hereby certify that I attended the deceased from 9/1/46
_____ 19____ to Sept. 3rd 1946
that I last saw her alive on Sept. 3rd 1946
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race W
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife THOMAS COLLINS alive _____ years
6. (c) Age of husband or wife if 18 years
7. Birth date of deceased AUGUST 8 1890
(Month) (Day) (Year)

Immediate cause of death Myocardial infarction from right bundle branch block Duration 3 days
Due to Hypertensive Cardiovascular disease 2 years
Due to _____
Other conditions: Unusually of abdominal aorta
(Include pregnancy within 3 months of death)

8. AGE: Years 76 Months 0 Days 25 If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) / INDIANA (State or foreign country)
10. Usual occupation Nil

Major findings: _____
Of operations _____
Of autopsy Denied
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business _____
12. Name UNKNOWN MARRINGER
13. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN UNKNOWN
15. Birthplace UNKNOWN UNKNOWN
(City, town, or county) (State or foreign country)
16. (a) Informant Mrs Sallie Eckhardt
(b) Address 3538 Vista Av
17. (a) BURIAL (b) Date thereof SEPT-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery
18. (a) Signature of funeral director E. J. Johnson
(b) Address 3125 Lafayette Av
19. SEP 4 1946 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

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 Richard C. ... 1515 Lafayette 9/4/46
Address _____ Date signed _____

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.....

Joe B. Kollmer

Licensed Embalmer No. *4014*

P. O. Address.....

St. Louis

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.