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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 19 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

17102

State File No.

Registrar's No. 387A

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution Springfield Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution nineteen days
(Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ozark 77

(c) City or town Brixey - Rural
(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

3. (a) PRINT FULL NAME GEORGE WASHINGTON COLLINS

3. (b) If veteran, name war —

3. (c) Social Security No. none

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Nancy E. Collins

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased Feb. (Month) 28 (Day) 1869 (Year)

8. AGE: Years 78 Months 1 Days 29 If less than one day hr. min.

9. Birthplace unknown (City, town, or county) Tenn. (State or foreign country)

10. Usual occupation Farming

11. Industry or business

FATHER

12. Name Harrison Collins

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

MOTHER

14. Maiden name Sarah Williams

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

16. (a) Informant Joe Bushong

(b) Address Brixey Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-29-47 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Lebanon Cem.

18. (a) Signature of funeral director Clinkingbeard Funeral Home

(b) Address Gainesville Mo

19. (a) 5-2-47 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 27 year 1947 hour 2 minute 17 A. M.

21. I hereby certify that I attended the deceased from April 8, 1947, to April 27, 1947; that I last saw him alive on April 26, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hypostatic Bronchopneumonia	72 hrs
Due to Chronic Nephritis	UK
Due to Prostatic Obstruction	Long
Other conditions Generalized Arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations Hypertrophic Prostatectomy
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) O

While at work? (e) Means of injury

23. Signature Robert Glynn (M. D. or other) MD

Address Springfield Date signed 4-27-47

(Licensed Embalmer's Statement on Reverse Side)

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 WB Hutchison

Licensed Embalmer No. 3431

P. O. Address Ava 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.