

FILED JUN 24 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

20556

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

506

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If inside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St John Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 da
(Specify whether
In this community 11 da
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46
(c) City or town West Plains 0
(If inside city or town limits, write "RURAL") 0
(d) Street No. R#3 (If rural, give location) 1
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME

James Bennett Collins

3. (b) If veteran, name war No

3. (c) Social Security No. _____

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Corra Collins 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased: May 27 1872
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 16
If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER } 12. Name Isaiah Collins

13. Birthplace Howell Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Rachel Hood

15. Birthplace Howell Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Corra Collins

(b) Address West Plains, Mo, R#3

17. (a) Burial (b) Date thereof 6-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains, Mo.

18. (a) Signature of funeral director Norman Schary Funkhouser
(b) Address Springfield Mo

19. (a) 6-14-47 (b) W E Handley M D
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 13
year 1947 hour 12 minute 45 P M.

21. I hereby certify that I attended the deceased from June 2nd 1947 to June 13 1947
that I last saw him alive on June 13 1947
and that death occurred on the date and hour stated above.

Immediate cause of death: auricular fibrillation & myocarditis. Duration 24 Hrs

Due to Benign Hypertrophy Prostate Duration 2 yrs

Due to _____
Other conditions: 9:30
(Include pregnancy within 3 months of death)

Major findings: Hypertrophy Prostate PHYSICIAN _____
Of operations _____
Of autopsy _____
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) _____
(e) Means of injury 0

23. Signature Edward Johnson (M. D. or other) _____
Address Springfield Mo Date signed 6/14/47

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

9
2
6

JUL 1 1947

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 *Lewis G. Scherpf*

Licensed Embalmer No. *3802*

P. O. Address *Springfield 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.