

No. 2
8-13
5-17-39
37823

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20774

Registration District No. 141

Primary Registration District No. 3025

Registrar's No.

1. PLACE OF DEATH:

(a) County Hawell

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

(c) Name of hospital or institution:
West Plains Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days
(Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Willa MAE Collins

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years _____ (Day) _____ (Year)

7. Birth date of deceased Nov 7 1922
(Month) (Day) (Year)

8. AGE: Years 15 Months 6 Days 1 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Earl Collins

13. Birthplace Douglas County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Hester Boone

15. Birthplace Hawell County Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Collins

(b) Address Willow Springs, Rural

17. (a) Burial (b) Date thereof May 9 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat Rock Cemetery

18. (a) Signature of funeral director Burns & Sons

(b) Address Willow Springs, Mo.

19. (a) 7-2-47 (b) Bertie Cook
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Hawell 46

(c) City or town Willow Springs Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Rural
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 8
year 1947 hour 11:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from 5/4 1947 to 5/8 1947
that I last saw her alive on 5/8 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Interstitial Nephritis

Due to _____

Due to _____

Duration 10 days

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations (M)

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? (O)

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Maurice Gaudin (M. D. or other) M.D.
Address West Plains Mo. Date signed 5/10/47

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

RECEIVED

District Officer No. 5,

District No. 647339

Date Filed 6-28-47

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.

Body not embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.

Registration District No. 141

Primary Registration District No. 0025

1. PLACE OF DEATH:
(a) County Haskell
(b) City or town West Plains
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Willie Mae Collins
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov 7 (Month) (Day) (Year)

8. AGE: 15 Years Months Days If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER {
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) July 2 - 1947 (b) Beatrice Cook
(Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

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

PHYSICIAN _____
Major findings: _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-20774