

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED NOV 12 1948 318
Registration District No.

FEDERAL BUREAU OF INVESTIGATION
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. **34016**
Registrar's No. **9385**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 Mos 10 das
(Specify whether 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. 4753 Washington
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

3: (a) PRINT FULL NAME Claude Collins
 3. (b) If veteran, name war..... 3. (c) Social Security No.

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased 6 17 1889
(Month) (Day) (Year)

8. AGE: Years 59 Months 4 Days 11 If less than one day hr. min.

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

10. Usual occupation Mechanic

11. Industry or business.....

12. Name James Collins

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

14. Maiden name Harriett Snorden
(City, town, or county) (State or foreign country)

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

16. (a) Informant Emma Collins

(b) Address Sparta Ill

17. (a) Removal (b) Date thereof 10-21-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sparta Ill

18. (a) Signature of funeral director Rowland Mortuary Service
 4104 Manchester Ave.
 (b) Address OCT 30 1948
 (Date received local registrar) (c) J B Lasater
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 28
 year 1948 hour 6 minute 35 a M.

21. I hereby certify that I attended the deceased from Aug. 18, 1948, to Oct. 28, 1948
 that I last saw him alive on Oct. 28, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Psoas Muscle, right-Sarcoma; Kidneys - Hydronephrosis
 Duration.....

Due to.....
 Due to.....
 Other conditions Lungs - congestion
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy Yes

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) means of injury 10
 23. Signature Charles R. Hozer (M. D. or other)
 Address 2601 N Whittier Date signed 10/29/48

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

9385

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 Ronald O Yalowitz

Licensed Embalmer No. 3917

P. O. Address. St Louis 10 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.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County.....
 (b) City or town St Louis
(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 Claude Collier
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex m 5. Color or race B
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if June 17 1948
Alive

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

8. AGE: Years 39 Months 4 Days.....
If less than one day

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

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) (Burial, cremation, or removal)..... (b) Date thereof.....
(Month) (Day) (Year)

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

19. (a) (Date received local registrar)..... (b) NOV 16 1948
(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.....
 year 1948 hour..... minute..... M.
 21. I hereby certify that I attended the deceased from..... 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)

Major findings:
 Of operations.....
 Of autopsy.....

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

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-34016

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