

No. 2
-5-43
17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 30 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39227**
Registrar's No. **370**

Registration District No. **1** Primary Registration District No. **3000**

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

1. PLACE OF DEATH:
(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Laughlin Hospital and Clinic**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Sullivan** ¹⁰⁵
(c) City or town **Newtown**
(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 **Jessie Collins**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **14**
year **1948** hour **4** minute **20** A. M.
21. I hereby certify that I attended the deceased from **12/9/48**
that I last saw **him** alive on **Dec. 14**, 19 **48**
and that death occurred on the date and hour stated above.

4. Sex **male** 0 5. Color or race **white**
6. (a) Single, widowed, married, divorced, **widowed**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **12 20 1860**
(Month) (Day) (Year)

Immediate cause of death **Uremia secondary to prostatic hypertrophy** Duration _____
Due to **associated with pneumonia**
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years **87** Months **11** Days **24**
If less than one day hr. _____ min. _____

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

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

10. Usual occupation **Retired farmer**
11. Industry or business _____
12. Name **Jahugh Collins**
13. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

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 **2**
23. Signature **Carl Hargrave** (M, D, or other) **D.O.**
Address **Kirksville Mo** Date signed **12-14-48**

14. Maiden name **Mary Conner**
15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Julia Parrish**
(b) Address **Newtown Mo**
17. (a) **Burial** (b) Date thereof **11-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Newtown Cmt**
18. (a) Signature of funeral director **Judith Payne**
(b) Address **Newtown Mo**
19. (a) **12-21-48** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 10

State File Number 12-18-2205

Date Filed DEC 28 1948

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirkville, 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.