

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

17167

318

1003

4611

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY					
b. CITY OR TOWN ST. Louis		c. LENGTH OF STAY (in this place) 20 years		c. CITY OR TOWN ST. Louis					
d. FULL NAME OF HOSPITAL OR INSTITUTION 2716 <sup>a</sup> MILL ST				d. STREET ADDRESS (If rural, give location) 21-2716 <sup>a</sup> MILL					
3. NAME OF DECEASED (Type or Print) Philas Collins			a. (First)		b. (Middle)		c. (Last) Collins		
4. DATE OF DEATH (Month) (Day) (Year) May 22 1949			5. SEX Male		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		
8. DATE OF BIRTH Unknown			9. AGE (To years last birthday) abt-85		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Miss			12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME Philas Collins		13b. MOTHER'S MAIDEN NAME Mary	
14. NAME OF HUSBAND OR WIFE Lula Collins			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Chara Collins		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH 2 years +	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 9 (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H252		22. I hereby certify that I attended the deceased from 11-23-, 1947, to 5-22, 1949, that I last saw the deceased alive on 5-22, 1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.						23a. SIGNATURE W.H. G. Clark, M.D.	
23b. ADDRESS 2748 <sup>a</sup> Franklin Ave		23c. DATE SIGNED 5/24/49		24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 5/28/49		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		25. FUNERAL DIRECTOR'S SIGNATURE F.A. Green		25. FUNERAL DIRECTOR'S ADDRESS 4214 DeLmar		DATE REC'D BY LOCAL REG. MAY 25 1949		REGISTRAR'S SIGNATURE J. B. Laster	

(Licensed Embalmer's Statement on Reverse Side)

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

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.