

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38635

State File No.

FILED DEC 8 1953

Registrar's No. 71

BIRTH NO. _____ REG. DIST. NO. 96 PRIMARY REG. DIST. NO. 5348

03200
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Dallas		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Rural-Grant	c. LENGTH OF STAY (in this place) (township)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rocheport MO	d. STREET ADDRESS (If rural, give location) 0100
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED (Type or Print) a. (First) Wanda		b. (Middle) Maxine		c. (Last) Collins		4. DATE OF DEATH (Month) (Day) (Year) 10-18-53		
5. SEX F	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH 2-26-1918		9. AGE (In years last birthday) 34	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 22	IF UNDER 10 HRS. Min.
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) Kisssee Mills MO		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Ellis Bailey		13b. MOTHER'S MAIDEN NAME Elsie Stokes		14. NAME OF HUSBAND OR WIFE Howard Collins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 489-86-5415		17. INFORMANT'S SIGNATURE OR NAME Howard Collins		ADDRESS Rocheport MO	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 5015 BURG AR495 MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 18, 1953 P.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Motor Vehicle Collision	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature]		23b. ADDRESS [Address]		23c. DATE SIGNED 11-30-53	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 10-21-53	24c. NAME OF CEMETERY OR CREMATORY Maple Park Cem	24d. LOCATION (City, town, or county) (State) AR495 MO
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DATE REC'D BY LOCAL REG. 12/7/53	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Allen W. Vaughan	ADDRESS [Address]
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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 Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urban, Md.

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.