

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15069**  
Registrar's No. **1026**

FILED APR 27 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **312** PRIMARY REG. DIST. NO. **572**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY OR TOWN <b>Richmond Heights</b>	c. LENGTH OF STAY (in this place) <b>10 days</b>	c. CITY OR TOWN <b>Richmond heights</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>6340 Clayton</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>John</b> b. (Middle) <b>William</b> c. (Last) <b>Collins</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 19th, 1956</b>					
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>March 17th, 1896</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 Hrs. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. L. County</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>England</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Michael J. Collins</b>	13b. MOTHER'S MAIDEN NAME <b>Annie Murray</b>	14. NAME OF HUSBAND OR WIFE <b>Mary Farris Collins</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>187-20-9701</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Mary Collins</b> ADDRESS <b>6340 Clayton</b>

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) <b>diffuse peritonitis perforated colon.</b>		INTERVAL BETWEEN ONSET AND DEATH
	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.		

19a. DATE OF OPERATION <b>4/12/56</b>	19b. MAJOR FINDINGS OF OPERATION <b>diffuse peritonitis - ruptured sigmoid colon</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)
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?

I hereby certify that I attended the deceased from **4/10/56** 19, to **4/19/56** 19, that I last saw the deceased alive on **4/19/56** 19, and that death occurred at **11:30P** m., from the causes and on the date stated above.

22. SIGNATURE <b>Darrey A. Montgomery</b> (Degree or title)	23b. ADDRESS <b>607 - 7 Grand</b>	23c. DATE SIGNED <b>4/20/56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>4-23-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>

DATE REC'D BY LOCAL REG. <b>4-20-56</b>	REGISTRAR'S SIGNATURE <b>Herbert A. Dombrowski</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Donnelly</b> ADDRESS <b>3840 Lindell Blvd.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Marston

University Club

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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.....  
Signature of Student Embalmer

Signed..... *James Williams* .....

Licensed Embalmer No. *35*

P. O. Address *38407*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.