

Health, Welfare, Public Service

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 31710  
Registration District No. 149 Primary Registration District No. 1002 Registrar No. 3984

FILED SEP 19 1957

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1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Independence,</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Osteopathic Hosp.</b>		Length of stay in lb <b>25 Days</b>	d. STREET ADDRESS (If outside, give location) <b>11101 E. 23rd.</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>W.</b> Last <b>Collins</b>			4. DATE OF DEATH Month <b>August</b> Day <b>24,</b> Year <b>1957</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1890</b>	9. AGE (In years last birthday) <b>67</b>	FUNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Smithfield, Penn.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>George Collins</b>	13b. MOTHER'S MAIDEN NAME <b>Flora Kale</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs. Harriet Collins</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>90-09-0010</b>	17. INFORMANT Address <b>Mrs. Harriet Collins 11101 E. 23rd.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial degeneration with pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8/2/57</b> <b>7/3/57</b>
DUE TO (b) <b>acute myocardial infarction</b>		
DUE TO (c) <b>atherosclerosis of coronary arteries</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4201</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>9 p.m.</b> Month <b>8</b> , Day <b>24</b> , Year <b>1957</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Independence, Mo.</b>	COUNTY <b>Jackson</b>	STATE <b>Missouri</b>
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21. I attended the deceased from Death occurred at <b>9 pm - 8/24/57</b> to <b>8-24/57</b> and last saw her/him alive on <b>8/24/57</b> in on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Grover N. Gillum M.D.</b>	22b. ADDRESS <b>926-E-11th St</b>	22c. DATE SIGNED <b>8/26/57</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Aug. 27, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Missouri</b>
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24. FUNERAL DIRECTOR <b>Muehlebach Funeral Home 6800 Troost</b>	ADDRESS <b>6800 Troost</b>	25. DATE RECD. BY LOCAL REG. <b>8-26-57</b>	26. REGISTRAR'S SIGNATURE <b>Nora Munsell</b>
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(Licensed Embalmer's Statement on Reverse Side)

GROVER N. GILLUM USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION  
All diseases in Part I must be causally related.

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*Osteopathic Hosp.*

**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 *G. E. Nichols* .....

Licensed Embalmer No. *4997* .....

P. O. Address *6100 T. Road  
K.P. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.