

Health,
& Welfare
Public
Service

S. 300
v. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37298

STATE FILE NUMBER

FILED NOV 8 1957

318

Registration District No. Primary Registration District No.

1003

10346

Registrar No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|-------|
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Masonic Home of Mo.</u> | | | Length of stay in 1b | d. STREET ADDRESS <u>5351 Delmar Blvd.</u> | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>T</u> Last <u>Collier</u> | | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 20, 1885</u> | 9. AGE (In years last birthday) <u>71</u> | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | | |
| 13. FATHER'S NAME <u>Richard W. Collier</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Bowdan</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u> | | 16. SOCIAL SECURITY NO. <u>496-05-6803</u> | 17. HOME ADDRESS <u>Masonic Home of Missouri 5351 Delmar Blvd. St. Louis, Mo. - By C. Robertson Super</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a); (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) <u>Uremia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>592x</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 yrs.</u> | |
| 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.) <u>592x</u> | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ | | | 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 | | | COUNTY | | STATE |
| 21. I attended the deceased from <u>Mar 1956</u> to <u>Nov 2, 1957</u> last saw her alive on <u>Nov. 2, 1957</u> Death occurred at <u>5:20 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Harold E. Walters M.D.</u> | | | | 22b. ADDRESS <u>3720 Washington St. Louis Mo.</u> | | 22c. DATE SIGNED <u>11-2-57</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>Nov. 3, 1957</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Kansas City, Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Pleander Somo 6175 Delmar</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>NOV 4 '57</u> | | 26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> | |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

m & s

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 *Gustav W. Dietzle*.....

Licensed Embalmer No. *4329*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.