

FILED NOV 25 1957

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 106

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN <u>Excelsior Springs</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Excelsior Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>215 N. Kimball</u>			Length of stay in lb <u>55 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>215 N. Kimball</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>John</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1957</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-1885</u>		9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (City and state or country) <u>Muncie, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Michael F. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shea</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>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hallie Collins, 215 N. Kimball, Excelsior Springs, Mo.</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>Cerebral hemorrhage (severe)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>hypertension</u>							<u>a year.</u>	
DUE TO (c) <u>arteriosclerosis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							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.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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>August 11, 1957</u> <u>Nov. 15, 1957</u> and last saw <u>him</u> alive on <u>Nov. 15, 1957</u> Death occurred at <u>2:30 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							22c. DATE SIGNED <u>11/15/57</u>	
22a. SIGNATURE <u>M. D. Cracken</u> (Degree or title)				22b. ADDRESS <u>M. D. Excelsior Springs, Mo.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-18-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u>			
24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u>				25. DATE RECD. BY LOCAL REG. <u>11-18-57</u>		26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		



NOV 26 1957

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 *Lindell Jarnan*.....

Licensed Embalmer No. *45*

Excelsior Springs
P. O. Address.....

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.