

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-001300

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

WRITE
STUB

AMENDED

Registration District No. 147 Primary Registration District No. 1002 Registrar's No. 440

FILED VS FEB 14 1961

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Jackson</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Jackson</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>111 So. Bellaire</u>		Length of stay in 1b <u>68 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>111 So. Bellaire</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last			4. DATE OF DEATH Month Day Year				
<u>JOSEPH JEFFERSON COLLINS</u>			<u>1 - 26 - 1961</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>3/10/1892</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Drug</u>		11. BIRTHPLACE (City and state or country) <u>K.C., Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Jefferson D. Collins</u>			13b. MOTHER'S MAIDEN NAME <u>Janthe A. Corder</u>		14. NAME OF HUSBAND OR WIFE <u>Chlova H. Collins</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>487-16-9839</u>		17. INFORMANT <u>ROBERT Mc Donald (Stepson)</u> Address <u>17209 E 28 Ter., INDEP. MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u>							<u>30 Days</u>
DUE TO (b) <u>Branchitis severe</u>							<u>1 year</u>
DUE TO (c) <u>Arteriosclerosis</u>							<u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>4 PM, 1959</u> to <u>1-26-61</u> and last saw him alive on <u>1-24-61</u>							
Death occurred <u>4 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>John Skinner MD</u> (Degree, or title)			22b. ADDRESS <u>1107 Grand Blvd</u>			22c. DATE SIGNED <u>1-27-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1-28-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo</u>		
24. FUNERAL DIRECTOR <u>C. N. Blackburn & Son K.C., Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>1-27-61</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>		

(Licensed Embalmer's Statement on Reverse Side)

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

John F. Skinner

Dr. Skinner
Bryant Bldg

V.I. Y-7010

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 _____

Licensed Embalmer No. _____

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.