

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**61-033814**

STATE FILE NUMBER

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 118

**FILED SEP 21 1961**

1. PLACE OF DEATH a. COUNTY <b>Pike</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Pike</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Louisiana</b>		Length of stay in 1b <b>2 1/2 Mo</b>	c. CITY OR TOWN <b>Curryville</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>Pike County Hospital</b> INSTITUTION <b>Louisiana</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>HighWay 54</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Nannie</b> Middle <b>Bell</b> Last <b>Collins</b>	4. DATE OF DEATH Month <b>Sept</b> Day <b>13</b> Year <b>1961</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1872</b>	9. AGE (last birthday) <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home Making</b>	11. BIRTHPLACE (City and state or country) <b>Pike County Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Robert D. Sterne</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Martin</b>	14. NAME OF HUSBAND OR WIFE <b>William B. 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>None</b>	17. INFORMANT <b>Willa Mac Smith, Louisiana, Mo.</b> Address
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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>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Arteriosclerosis and Arteriovenous Aneurysm</b>	
	DUE TO (c) <b>Heart Disease</b>	

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
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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 _____ a.m. _____ p.m. Month, Day, Year _____
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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 _____
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21. I attended the deceased from 8/1/61 to 9/13/61 and last saw her/him alive on 9/12/61  
Death occurred at 12:27 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>John K. Holcomb, M.D.</b> (Degree or title)	22b. ADDRESS <b>Louisiana, Missouri</b>	22c. DATE SIGNED <b>9/15/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/15/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Kilby Cemetary</b>	23d. LOCATION (City, town, or county) <b>8 Mi S.W. Curryville, Mo.</b>
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24. FUNERAL DIRECTOR <b>Sterne Funeral Home Louisiana, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>Sept 18 - 61</b>	26. REGISTRAR'S SIGNATURE <b>Blanche Collier</b>
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AMENDED  
 DATE AMENDED  
 INSTEAD OF  
 THIS RECORD ARE AS FOLLOWS  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

**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 J.B. Steene

Licensed Embalmer No. 4039

P. O. Address Louisiana

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.