

SOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-046182
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11100**

AMENDED

FILED DEC 18 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI	Length of stay in 1b 2 Weeks	c. CITY OR TOWN East St. Louis	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1449 Lawrence Avenue	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ANDERSON Middle COLLIER Last			4. DATE OF DEATH Month NOVEMBER Day 28 Year 1961			
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/10/76	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and state or country) DeSoto, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME RICHARD COLLIER		13b. MOTHER'S MAIDEN NAME ELIZABETH COMEMAN		14. NAME OF HUSBAND OR WIFE None		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Jodie White, 511 Cross St., Herculaneum, Mo.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ILEOCECAL INTUSSUSCEPTION		INTERVAL BETWEEN ONSET AND DEATH 1-2 MONTHS
DUE TO (b) CARCINOMA OF STOMACH AND PROSTATE		1 YEAR
DUE TO (c) 151X		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MYOCARDIAL INFARCTION, PREVIOUS		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.)	
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 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 **APRIL 6, 1956**, to **NOV. 28, 1961** and last saw her/him alive on **NOVEMBER 28, 1961**
Death occurred at **9:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) F. R. BRADLEY, M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 11/28/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/3/61	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) (State) Centreville Township, Illinois
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24. FUNERAL DIRECTOR ADDRESS Marion's Clinic, 2114 Missouri Ave. St. Louis, Ill.	25. DATE RECD. BY LOCAL REG. NOV 29 1961	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

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 Frank Prokop

Licensed Embalmer No. 4356

P. O. Address St Louis 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.