

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-000215

STATE FILE NUMBER

AMENDED

Registration District No. 3-8

Primary Registration District No. 3006 Registrar's No. 47

FILED JAN 29 1962

1. PLACE OF DEATH a. COUNTY <u>Boone</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Columbia</u>		Length of stay in 1b <u>40 days</u>	c. CITY OR TOWN <u>Osceola</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ellis Fischel State Cancer</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>	
3. NAME OF DECEASED (Type or print) First <u>Nels</u> Middle <u>Collins</u> Last <u>Collins</u>			4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1962</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>7-4-74</u>	9. AGE (last birthday) <u>887</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
IF UNDER 24 HR Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Denmark</u>	12. CITIZEN OF WHAT COUNTRY <u>unknown</u>
13a. FATHER'S NAME <u>Sorn Collins</u>		13b. MOTHER'S MAIDEN NAME <u>Christina Nelson</u>		14. NAME OF HUSBAND OR WIFE <u>Widowed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Hospital Records- Columbia, Missouri</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>Ulcerative Colitis, bacterial, severe</u> DUE TO (b) <u>Dissective enteritis coli - severe</u> DUE TO (c) <u>Post-op status - Colostomy & cystostomy</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 checked="" type="checkbox"/> NO <input 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 <u> </u> a.m. <u> </u> p.m. <u> </u>	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>1-2-62</u> to <u>1-23-62</u> and last saw her/him alive on <u>1-23-62</u> Death occurred at <u>4:00 A.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert J. Woovers M.D.</u>			22b. ADDRESS <u>State Cancer Hospital</u>		22c. DATE SIGNED <u>1/23/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>1-26-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OSCEOLA CEM.</u>	23d. LOCATION (City, town, or county) <u>OSCEOLA MO</u>		
24. FUNERAL DIRECTOR <u>Hoodlick & Home Osceola Mo</u>		ADDRESS <u> </u>	25. DATE RECD. BY LOCAL REG. <u>Jan 23 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 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 Paul Trivestone

Licensed Embalmer No. 3990

P. O. Address Worcester, Ma

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.