

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016683

318

1003

4615

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4615**
FILED MAY 10 1962

VS 300
 Rev. 4/59
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 2 20
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 4 1
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 12 90-0
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DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 BY AFFIDAVIT OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis Mo		Length of stay in lb 49 Years	c. CITY OR TOWN St Louis Mo Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 5448 Cabanne Ave		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) 5448 Cabanne Ave Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Charles Collins			4. DATE OF DEATH Month Day Year 5 5 62
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-23-1890
9. AGE (last birthday) 71		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) Religious		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kirkwood Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Bernard Collins	
13b. MOTHER'S MAIDEN NAME Mary Josephine Leppeve		14. NAME OF HUSBAND OR WIFE Single	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mother Claude Agnes 5448 Cabanne Ave
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) 332X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) Coronary artery arteriosclerosis			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 1955 to Present and last saw her/him alive on 5/4/62 Death occurred at 8:15 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. J. Gold MD (Deceased or title)		22b. ADDRESS Northland Medical	
22c. DATE SIGNED 5/6/62		22d. (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-7-1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St Louis Mo
24. FUNERAL DIRECTOR ADDRESS Arthur J. Donnelly 3840 Lindell Blvd		25. DATE RECD. BY LOCAL REG. MAY 6 1962	26. REGISTRAR'S SIGNATURE Ernest Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

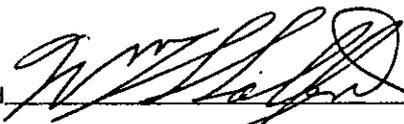
Dr Thomas H. Boldt
9904 Litzinger Rd

6-1-1965

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. 4699

P. O. Address 5840 Jendell

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.