

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043700

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 169

DO NOT WRITE ON THIS STUB

AMENDED

NOV 26 1963

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

3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Susan</u> Last <u>Collins</u>			4. DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1963</u>	
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5. SEX <u>Female</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>9-19-1877</u>	9. AGE (last birthday) <u>86 Years</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Douglas County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Joseph M. Cunningham</u>	13b. MOTHER'S MAIDEN NAME <u>Theora Cunningham</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Collins</u>
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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)	NO.	17. INFORMANT Address <u>Joe Collins, Willow Springs, Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Shock</u>		<u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>gastrointestinal hemorrhage</u>	<u>24 hrs</u>
	DUE TO (c) <u>mesenteric thrombosis</u>	<u>72 hrs</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic heart disease</u>	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 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 1957 to 11/15/63 and last saw her alive on 11/15/63  
Death occurred at 6 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. L. Fowler MD</u> (Degree or title)	22b. ADDRESS <u>West Plains Mo</u>	22c. DATE SIGNED <u>11/20/63</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-17-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Collins Cemetery</u>	23d. LOCATION (City, town, or county) <u>West Plains, Missouri</u>
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24. FUNERAL DIRECTOR <u>Robertson Funeral Home West Plains, Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>11-23-63</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 D. D. Robertson

Licensed Embalmer No. 3442

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.