MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Local No. 10246

1. PLACE OF DEATH
County Greene Registration District No. 318 File No.
Township Primary Registration District No. 2007 Registered No. 201
City Springfield Mo. Springfield Hosp. Ward)

2. FULL NAME Johnnie Pauline Collings
(a) Residence. No. Exeter Mo. Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female | 4. COLOR OR RACE White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 6-1911

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	4	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER E M Collings
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Ind
12. MAIDEN NAME OF MOTHER Florella Ersland
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo

14. INFORMANT E M Collings
(Address) Exeter Mo

15. FILED 3-4-29 OC Forst Mo.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 4 1929

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to March 4, 1929, that I last saw h.er alive on March 4 1929, and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pneumonic Abcess
133 Hr (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Flu
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Willis Smith M.D
, 19 (Address) Springfield Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cassville Mo | DATE OF BURIAL 3/6 1929
20. UNDERTAKER H H Lohmeyer | ADDRESS Springfield Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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