MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

File No. 25513

Registration District No. 741

Primary Registration District No. 5976 B Registered No. 459

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PLACE OF DEATH

County: Ray Co.

Township or Village or City: Richmond (NO. ..... St.: ..... Ward)

FULL NAME Jessie Collins

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE / MARRIED / WIDOWED / OR DIVORCED (Write the word): Single

DATE OF BIRTH: August (Month) 1 (Day) 1898 (Year)

AGE: 18 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): —

BIRTHPLACE (City or town, State or foreign country): Ray Co.

PARENTS
NAME OF FATHER: Sterrett Collins
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ray Co
MAIDEN NAME OF MOTHER: Nollie Hunter
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ray.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sterrett Hunter

(ADDRESS) Dockery

Filed July 1 1916 Geo W Hunt Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 30 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from March 1, 1916, to June 30, 1916, that I last saw her alive on June 27, 1916, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

23A

(Duration) ..... yrs. 6 mos. ..... ds.

Contributory (SECONDARY) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Cook M. D.

June 30, 1916 (Address) Rayville, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL: Dockery

DATE OF BURIAL: July 1 1916

UNDERTAKER: Tincnett & Co

ADDRESS: Richmond Mo

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

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day), *1* _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____ (Month) _____ (Day), *191*__ (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191__, to _____, 191__, that I last saw h_____ alive on _____, 191__, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL _____, 191__
UNDERTAKER	ADDRESS

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.

[illegible] for malignant neoplasms); *Measles; Whooping cough;* [illegible] term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive* [illegible] *Chronic valvular heart disease; Chronic interstitial*