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

30782

1 PLACE OF DEATH

County .....

Township ..... Registration District No. 781 File No. .....

or

Village ..... Primary Registration District No. 1003 Registered No. 8691

or

City St Louis (NO. ..... City Hospital St. 19 Ward)

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

2 FULL NAME 726 Eliza Collins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Not Known (Month) (Day) (Year)

7 AGE: 43 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (City or town, State or foreign country): Texas.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Texas

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Not Known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

(Informant) C Kowan

(Address) City Hospital

15 Filed SEP 17 1918, 191.. Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept 15 (Month) (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 13, 1918, to Sept 15, 1918 that I last saw h. alive on Sept 14, 1918 and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage, apoplexy

64

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

CONTRIBUTORY (Secondary) Bronchio-pneumonia

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

(Signed) Emil A Jeni M. D.

Sept 15, 1918 (Address) City Hospital

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

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. 2 ds. In the State ..... yrs. 6 mos. ..... ds.

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

Former or usual residence 2847 Lucas

19 PLACE OF BURIAL OR REMOVAL: Hempstead Tex

DATE OF BURIAL: Sept. 18, 1918

20 UNDERTAKER: Harrison & McKown

ADDRESS: 2906 Lawton

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

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 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.

Collins

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