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

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.

PLACE OF DEATH

County Gentry

Township ~~Eastport~~

or Village

or City Stanberry (NO. ____ 2nd St.; ____ Ward)

Registration District No. 314 — File No. 709 [redacted]

Primary Registration District No. 4190 — Registered No. 2

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

FULL NAME Robert Kenneth Collier

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	✓

DATE OF BIRTH: July (Month) 26 (Day), 1918 (Year)

AGE: 3 yrs. 5 mos. 28 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION (Trade, profession, or particular kind of work): ✓

(General nature of industry, business, or establishment in which employed (or employer)): ✓

BIRTHPLACE (City or town, State or foreign country): Council Bluffs Iowa

NAME OF FATHER: Lewis Collier

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

MAIDEN NAME OF MOTHER: Lottie Mae Runyon

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

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant: L. M. Collier

(ADDRESS) Stanberry Mo

Filed Jan 26, 1922 Ina E Goerdes Dep REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 3.15 A.M. January (Month) 24 (Day), 1922 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 22, 1922, to Jan 24, 1922, that I last saw him alive on Jan 24, 1922, and that death occurred, on the date stated above, at 3.15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Follicular Tonsilitis

(Duration) ____ yrs. ____ mos. 4 ds.

Contributory (SECONDARY) Acute Cervical Adenitis

(Duration) ____ yrs. ____ mos. 3 ds.

(Signed) E. E. Simpson M. D.

1/25, 1922 (Address) Stanberry 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: Hill Ridge — DATE OF BURIAL: Jan 25, 1922

UNDERTAKER: E. P. Pennington — ADDRESS: Stanberry

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

PLACE OF DEATH

County Gentry

Township Cooper

or

Village

or

City (NO. St.; Ward)

Registration District No. File No.

Primary Registration District No. Registered No.

[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) (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 Sept 24, 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

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