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

Do not use this space.

10681

File No. 1188

Registered No.

1. PLACE OF DEATH

County: Jackson

Township: Kaw

City: K. C. Mo. (No. 5500 Forest St. Ward)

Registration District No. 399

Primary Registration District No. 1002

2. FULL NAME George Walker Collier

(a) Residence: No. 5500 Forest St., 15 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M.	wh.	widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-20-1850

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78	2	20	

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

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

PARENTS

10. NAME OF FATHER Lewis K. Collier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Madison Co.
(STATE OR COUNTRY) Ill.

12. MAIDEN NAME OF MOTHER Mary Ann Ruff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Mo.

14. INFORMANT S. G. Collier
(Address) Olathe, Kansas

15. FILED 3/11, 19 29 M. M. Browne
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-10- 1929

17. I HEREBY CERTIFY, That I attended deceased from 3-8, 1929, to 3-10, 1929, that I last saw h. alive on 3-10, 1929, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

93 HR

102 740.1

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) High Blood Pressure

(duration) 10 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? No DATE OF —

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? None

(Signed) E. J. Drummond, M. D.

3/11, 19 29 (Address) 5450 Troost Ave

*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	DATE OF BURIAL
Rossville, Kans	3-13 1929
20. UNDERTAKER	**ADDRESS**
Mrs. C. L. Forster	K. C. 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.

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

55 [illegible] & [illegible]

[illegible]

Willard 7160