

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

Do not use this space.

36301

1. PLACE OF DEATH

County Bollinger
Township Wayne
City (No. _____) _____

Registration District No. 69
Primary Registration District No. 5708

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

James M. Collier
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Martha M. Collier

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 28 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
71 5 _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer
(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

10. NAME OF FATHER William M. Collier

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) mo

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Martha M. Collier
(Address) Galena mo

15. FILED 12-15-29 D. P. Kirkpatrick
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1929 to Nov 28 1929
that I last saw him alive on Nov 26 1929, and that death occurred, on the date stated above, at 9 P. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
107A (duration) yrs. mos. da. 8

CONTRIBUTORS (SECONDARY) 107A (duration) yrs. mos. da. _____

18. WHERE WAS DISEASE CONTRACTED at his home
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) D. P. Kirkpatrick M. D.
, 19 (Address) Galena 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 Cato Cemetery DATE OF BURIAL Nov. 30 1929

20. UNDERTAKER W. Morgan ADDRESS Galena Mo

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.

12-15-29
D. P. Kirkpatrick

MISSOURI