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

Do not use this space.

5303

1. PLACE OF DEATH

County Jackson Dental — Registration District No. 393

Township Kansas — Primary Registration District No. [illegible]

City K.C. Mo. (No. General Hospital #2 St. Ward)

File No.

Registered No. 5303

2. FULL NAME Geo. Collins

(a) Residence. No. 1746 Bellview St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 3-27-1893

7. AGE: 36 YEARS — MONTHS: 10 — DAYS: 8 — If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(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.

PARENTS

10. NAME OF FATHER: Allen Johnson

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

12. MAIDEN NAME OF MOTHER: Wah Ella

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

14. INFORMANT: Record Clerk (Address) Gen Hosp #2 K.C. Mo.

15. FILED 3/28, 1930 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 5, 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1930, to Feb 5, 1930, that I last saw him alive on Feb 5, 1930, and that death occurred, on the date stated above, at 1.50 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Cystitis / Pyelitis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) 131 W

(duration) ....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?

(Signed) H. M. Smith, M. D.

2/6, 1930 (Address) Genl Hospt #2

*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: K.C. Western Dental Col — DATE OF BURIAL: 2-19 1930

20. UNDERTAKER: Mo. St. Anatomical Board — ADDRESS: L. V. Hill Secty.

3-27-1892