

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

Do not use this space.

14560

1. PLACE OF DEATH

County..... Registration District No. 70m
 Township..... Primary Registration District No. 1000
 City St. Louis (No. 4042A Chestnut St. St. _____ Ward)

2. FULL NAME

Thomas J. Collins
 (a) Residence. No. 4042A Chestnut St. 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 Male 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 Bella Collins

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 20, 1858

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
70 3 28

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Wood Worker
 (b) General nature of industry, business, or establishment in which employed (or employer) North St. R. Planning
 (c) Name of employer Muller

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo.

10. NAME OF FATHER Thomas Collins

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Bella Collins
 (Address) 4042 Chestnut St.

15. FILED 1930 May 2 Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-18-1930

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1930 to April 17, 1930 that I last saw h. alive on April 17, 1930, and that death occurred, on the date stated above, at 7 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuber Pneumonia
108 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) 10/13 (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) M. J. Sheets M. D.
4/19/1930 (Address) 4300 Manchester

*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 Calvary Cemetery DATE OF BURIAL 4-21-1930
 20. UNDERTAKER Friegshauser, U. Manchester ADDRESS 4104

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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