Do Duffy

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

Do not use this space.

39165

JAN 19 1931

1. PLACE OF DEATH
County Trudy — Registration District No. 330 — File No.
Township — Primary Registration District No. 3017 — Registered No.
City Trenton (No. 200 Kitty St. 4th Ward)

2. FULL NAME John W. Collins
(a) Residence. No. 200 Kitty St., 4 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): widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar 26, 1862

7. AGE: YEARS 68 — MONTHS 8 — DAYS 26 — If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(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): Iowa

PARENTS
10. NAME OF FATHER: Henry Collins
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio
12. MAIDEN NAME OF MOTHER: Mary Slovens
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ohio

14. INFORMANT: Mrs. Kent
(Address) 200 Kitty St.

15. FILED Dec 24 1930 — E. A. Duffy, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): Dec 22 1930

17. I HEREBY CERTIFY, That I attended deceased from 24 Nov, 1930, to 22 Dec, 1930 that I last saw him alive on 22 Dec, 1930, and that death occurred, on the date stated above, at 5 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Tuberculosis Lungs
23A
11A
107A
31
(duration) several yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
Influenza + Broncho Pneumonia (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? Phys signs + findings
(Signed) E. A. Duffy, M. D.
24 Dec 1930 (Address) Trenton 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: KOP. Cemetery.
DATE OF BURIAL: 12/24/1930

20. UNDERTAKER: Gypson Furn Co.
ADDRESS: Trenton 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.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

County.................... Registration District No.................... File No....................

Township.................... Primary Registration District No.................... Registered No....................

City.................... (No.................... St., ... Ward)

2. FULL NAME....................

(a) Residence. No.................... 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

4. COLOR OR RACE

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

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

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

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

8. OCCUPATION OF DECEASED

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

(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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT....................
(Address)

15. FILED...................., 19.... ....REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from...................., 19......, to...................., 19....

that I last saw h.......... alive on...................., 19......, 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH....................

DID AN OPERATION PRECEDE DEATH?.......... DATE OF....................

WAS THERE AN AUTOPSY?....................

WHAT TEST CONFIRMED DIAGNOSIS?....................

(Signed).................... M. D.

...................., 19 (Address)

*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 19

20. UNDERTAKER | ADDRESS

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.