

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.

MAR 24 1934

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 791

Do not use this space.

1. PLACE OF DEATH

County _____ Registration District No. **1003**
Township _____ Primary Registration District No. _____
City **M. L. Linn** (No. **3112**) **W. Taylor** St. _____ Ward _____

File No. **6507**
Registered No. **1348**

2. FULL NAME **Elizabeth Collins**

(a) Residence, No. **3112 W. Taylor** St. **10** 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 **Female** 4. COLOR OF RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED **Married**

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
about 74

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**

13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

15. MAIDEN NAME **Unknown**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

17. INFORMANT (ADDRESS) **Wm. P. Dehaenen 3112 W. Taylor Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Feb 8 34**

19. UNDERTAKER (ADDRESS) **Frank Carroll 1600 North Bridge**

20. FILED **1934** **J. A. Bredeck** Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb 5 1934**

22. I HEREBY CERTIFY. That I attended deceased from **Feb 3 1934** to **Feb 5 1934**. I last saw her alive on **Feb 5 1934**. Death is said to have occurred on the date stated above, at **1025 A.M.**

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset **1925**

92C
97
112
Other contributory causes of importance: Bronchial Asthma and General Arteriosclerosis **5790**

Name of operation _____ Date of _____
What test confirmed diagnosis? **Clinical** Was there an autopsy? **NO**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? **NO**
If so, specify _____

(Signed) **R. E. Owen** M. D.
(Address) **University Club Bldg**

