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.

AUG 8 1934

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

Do not use this space.

24104

1. PLACE OF DEATH Greene
County Greene — Registration District No. 318 — File No. 331
Township — Primary Registration District No. 2001 — Registered No.
City Springfield (No. 1401 N. Johnson St. Ward)

2. FULL NAME Margaret E. Collier
(a) Residence, No. 1401 N. Johnson 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 Female
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 Wm. E. Collier

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 29 - 1862

7. AGE — YEARS 72 — MONTHS 1 — DAYS 14 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. House Work
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) Mo.

FATHER
13. NAME G. W. Moreland
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Mary Bowman
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

17. INFORMANT (ADDRESS) Wm. E. Collier Springfield, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE East Lawn Cemetery DATE July 15 1934

19. UNDERTAKER (ADDRESS) J. W. Klingner & Co. Springfield, Mo.

20. FILED 7-14, 1934 [signature] Registrar.
Ralph W. Langston

MEDICAL CERTIFICATE OF DEATH

3

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-13, 1934

22. I HEREBY CERTIFY, That I attended deceased from July 8, 1934, to July 13, 1934
I last saw her alive on July 11, 1934. Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	7-1-34
Paralysis	

Other contributory causes of importance:
Arteriosclerosis ?

Name of operation ..... Date of .....
What test confirmed diagnosis? Clinical Was there an autopsy? .....

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) Arthur D. Knab, M. D.
(Address) 450½ E. Cornil