

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.

ACT 13 1924

1. PLACE OF DEATH  
94 County St. Francois  
Township  
3 City Bismarck

Registration District No. 771  
Primary Registration District No. 4462

File No. 30571  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward)

2. FULL NAME Ellice E. Collins  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward. \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred 4 1/2 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug. 12 - 1852</u>		
7. AGE YEARS <u>81</u>	MONTHS <u>11</u>	DAYS <u>22</u>
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>none</u>		
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. <u>none</u>		
10. Date deceased last worked at this occupation (month and year) <u>none</u>		
11. Total time (years) spent in this occupation. <u>none</u>		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Fredonia Mo.</u>		
13. NAME <u>Samuel Collins</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Kentucky</u>		
15. MAIDEN NAME <u>Caroline Williams</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Fredonia Mo.</u>		
17. INFORMANT <u>Miss Cora Williams</u> (ADDRESS) <u>Bismarck Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Fredonia Mo.</u> DATE <u>Aug. 6</u> 19 <u>34</u>		
19. UNDERTAKER <u>White &amp; Heltz</u> (ADDRESS) <u>Bismarck Mo.</u>		
20. FILED <u>Oct 10</u> 19 <u>34</u> <u>E. M. Bryan M.D.</u> Registrar.		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 4 1934

22. I HEREBY CERTIFY, That I attended deceased from May 5 - 1934 to Aug. 12 - 1934  
I last saw h fr alive on Aug. 6 1934 Death is said to have occurred on the date stated above, at 3 a. m.  
The principal cause of death and related causes of importance were as follows:  
Uremic Poison  
Date of onset \_\_\_\_\_

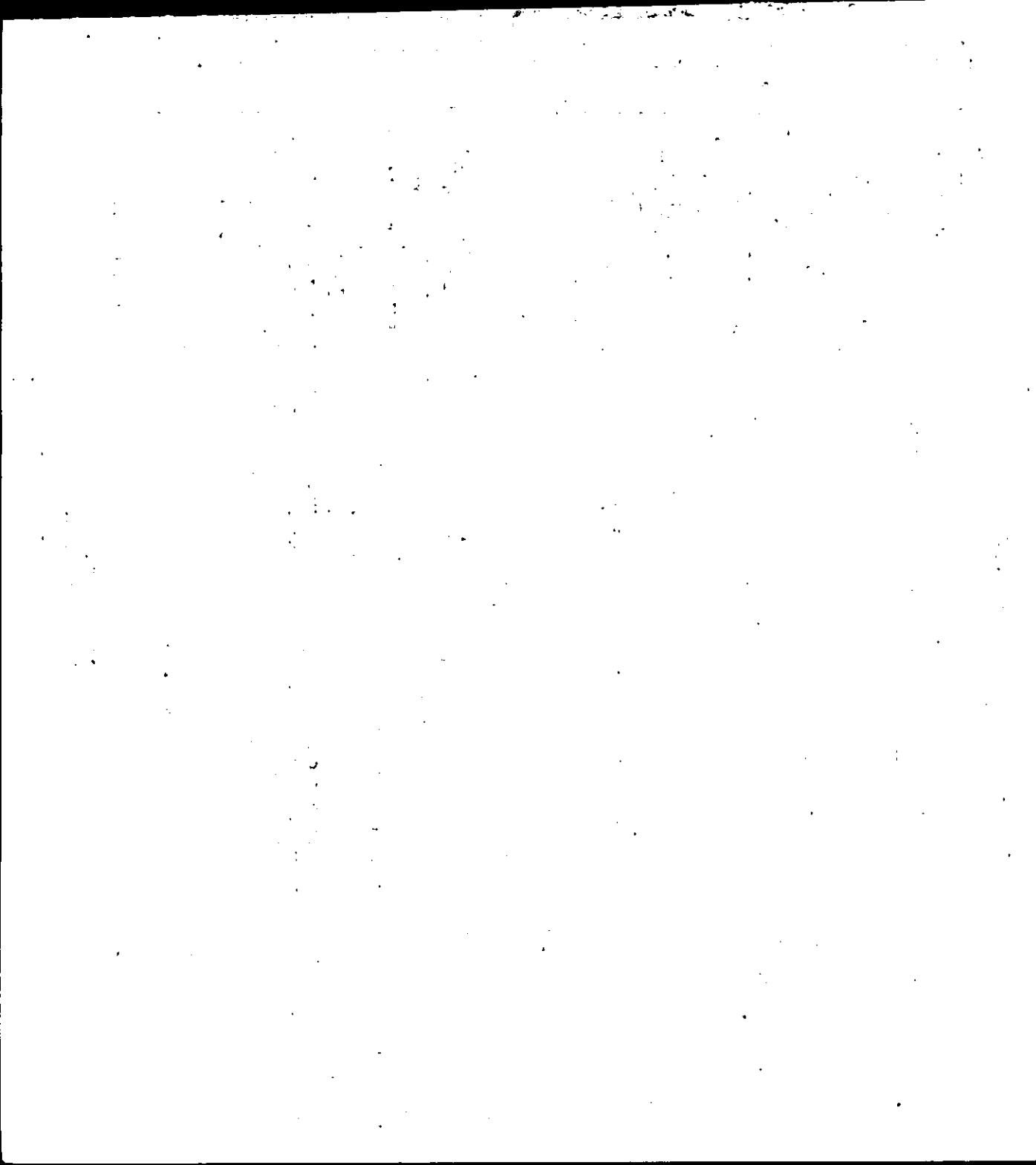
Other contributory causes of importance:  
Infirmity of old age

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ 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) J. W. Gale M. D.  
(Address) Bismarck Missouri



*St. Francois*

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Alice E. Collier*  
Who died at \_\_\_\_\_ on *Aug 4 - 1934*  
Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
Sex *F* Color or race *W* Single, married, widowed or divorced: \_\_\_\_\_

Date of birth \_\_\_\_\_ Age: Years *81* Months *11* Days *22*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: *Ureine Pearson* Month \_\_\_\_\_ Year \_\_\_\_\_  
Birthplace (State or country) \_\_\_\_\_ Primary Disease: \_\_\_\_\_  
Birthplace of father (State or country) *Chronic parenchymatous nephritis*  
Birthplace of mother (State or country) \_\_\_\_\_  
Principal cause of death: \_\_\_\_\_

Other contributory causes of importance *In families of old age. 121*  
Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
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 \_\_\_\_\_  
Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
Name of physician *F. W. Gale - Des Moines Mo*  
Address of physician \_\_\_\_\_

X Signature of Registrar *E. M. Ryan M.D.* Date filed *Oct. 22, 1934.*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *771*  
Primary Reg. Dist. No. *4462*

Very truly yours,

*E. T. McLaugh*

Special Agent

S-30571

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