

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

Do not use this space.

39841
4988

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township 1st Primary Registration District No. 2
 City St. Mo. (No. General Hospital) St. 3rd Ward)

2. FULL NAME Willie L. Collier
 (a) Residence, No. 523 Grand 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 Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-20-1889

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>48</u>	<u>9</u>	<u>3</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labourer

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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-23, 1935

22. I HEREBY CERTIFY, That I attended deceased from 12-18, 1935, to 12-23, 1935

I last saw him alive on 12-23, 1935 Death is said to have occurred on the date stated above, at 1200 Union

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

Lober Pneumonia (Right)

Date of onset _____

Other contributory causes of importance: 108

Name of operation Clinical Lab Date _____
 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) P. O. Brown, M. D.
 (Address) General Hosp

OCCUPATION

MOTHER FATHER

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

13. NAME Deceased

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) Record Dept

18. BURIAL OR CREMATION OR REMOVAL PLACE Keokuk DATE 12-31, 1935

19. UNDERTAKER (ADDRESS) Hatchers 520 N. 5th - N.O.K.

20. FILED 12-31, 1935 m.m. Brown asst. Registrar.

MAR 13 1959

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

ALL INFORMATION OBTAINED
HEREIN IS UNCLASSIFIED
DATE 08-11-2010 BY 60322 UCBAW/STP

1. PLACE OF DEATH

County Jackson
Township J.C. mo
City J.C. mo (No. _____)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 4988
St. _____ Ward)

2. FULL NAME

Willie K. Collier

(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) Unknown

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.

OCCUPATION 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) _____

MOTHER, FATHER 13. NAME _____

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____ 19

19. UNDERTAKER (ADDRESS) _____

20. FILED 12/31 1935 Mr. M. Grove Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from _____, 19 _____, to _____, 19 _____

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

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ 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? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

14865-5