

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

**15941**  
Do not use this space.

REC'D MAY 22 1939

**1. PLACE OF DEATH**

(a) County St. Charles Registration District No. 757  
 (b) Township St. Charles Primary Registration District No. 3036  
 (c) City St. Charles (d) Street No. 525 Madison St. St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Minnie Cornelia Collins

(a) Residence, No. 525 Madison St. Charles, Mo. (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 5, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
64 8 19

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housework  
 9. Industry or business in which work was done, as 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) St. Charles, Mo.

13. NAME William David Collins

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

15. MAIDEN NAME Cornelia Wells

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Charles, Mo.

17. INFORMANT (ADDRESS) Mrs. Edw. Price  
St. Charles, Mo.

18. BURIAL, CREMATION, OR REMOVAL St. Charles, Mo.  
 PLACE Oak Grove Cemetery DATE April 27, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. C. Hallmeyer & Sons Co.  
St. Charles, Mo.

20. FILED 4/27 1939 Clarence P. Hessler  
Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from April 14, 1939, to April 24, 1939.  
 I last saw her alive on April 24, 1939. Death is said to have occurred on the date stated above, at 7:30 P.M.  
 The principal cause of death and related causes of importance were as follows:

Intestinal Flu  
 Date of onset April 12, 1939  
11 h

Other contributory causes of importance:  
Flies Contact

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) T. P. Hendrix, M. D.  
St. Charles, Mo. (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.

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**