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.

REC'D JUN 19 1939

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

19154
Do not use this space.

1. PLACE OF DEATH
(a) County Macon — Registration District No. 532
(b) Township La Plata — Primary Registration District No. 5711 — Registered No.
(c) City Atlanta Mo — (d) Street No. ..... 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 452 Americus William Collins
(a) Residence, No. ..... St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
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~~ Ida Collins
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 16th 1863
7. AGE: YEARS 76 — MONTHS 1 — DAYS 18 — If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Farmer
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) Macon Co Mo — 0

FATHER
13. NAME Americus B. Collins — 1
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn — 0

MOTHER
15. MAIDEN NAME Mary Jane Ellison
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Monroe, Co. Mo

17. INFORMANT (ADDRESS) Frank Collins Atlanta Mo
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Tabor DATE May 26 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H M Boodding Atlanta, Mo.
20. FILED May 29 1939 Louise J. Smith 475 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May-24- 1939
22. I HEREBY CERTIFY, That I attended deceased from May-17- 1939, to May-24 1939
I last saw him alive on May-23- 1939. Death is said to have occurred on the date stated above, at 11 a.m.
The principal cause of death and related causes of importance were as follows:
Paralytic Stroke from Cerebral Thrombosis — Date of onset
92 A
Other contributory causes of importance:
Mitral Regurgitation and Myocarditis
Name of operation None 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) A. L. Carrhee, M. D.
(Address) Atlanta Mo

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 10-39-1069
Date Filed JUN 7 1939

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, ...
H M Boodding, or by .....
Registered Apprentice No....., working under my personal supervision.

Signed H M Boodding

Licensed Embalmer No. 1750

P. O. Address Atlanta Ma

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

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