

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

39775
Do not use this space.

1. PLACE OF DEATH
 (a) County Hickory Registration District No. 359
 (b) Township Wheatland Primary Registration District No. 4212 Registered No. 11
 (c) City Wheatland, 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 Chas. Porter Collins
 (a) Residence, No. _____ St. (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 m
 4. COLOR OR RACE Wht
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mahala Collins
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 14, 1849
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
90 6 13
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) Kentucky

FATHER 13. NAME Wm Collins

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

MOTHER 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Chas Collins
Wheatland Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Robinson DATE 11/28/39

19. FUNERAL DIRECTOR (ADDRESS) JR. Luster
Wheatland Mo

20. FILED 12/9 1939 Thos D Owens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 27 1939
 22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1938, to Nov 27, 1939
 I last saw him alive on Nov 25, 1939. Death is said to have occurred on the date stated above, at 7:00 a m.
 The principal cause of death and related causes of importance were as follows:

Chronic Interstitial Nephritis

Date of onset Unknown

Other contributory causes of importance: None

Name of operation _____ Date of _____
 What test confirmed diagnosis? Urinalysis 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. S. Johnston M. D.
 (Address) Wheatland Mo

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.

RECEIVED

District Health Officer No. 7,

District File Number 12-39-1734

Date Filed 12-13-39

STATEMENT BY LICENSED EMBALMER

I, J. H. Lecky, Licensed Embalmer No. 2982
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by Registered Apprentice No.
working under my personal supervision.

Signed J. H. Lecky
Licensed Embalmer No. 2982

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.)