

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Registration District No. **318**

Primary Registration District No. **2001**

1. PLACE OF DEATH:
(a) County **Greene** **2**
(b) City or town **Springfield**
(c) Name of hospital or institution **913 E. Dale St.**
(d) Length of stay: In hospital or institution _____
In this community _____ years, months or days **115**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **Greene**
(c) City or town **Springfield**
(d) Street No. **913 E. Dale**
(e) If foreign born, how long in U. S. A. _____ years

3. (a) PRINT FULL NAME **JAMES S. COLLINS**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **Dec** day **30**
year **1939** hour **2** minute **00** A. M.

4. Sex **male**
5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Golden A. Collins**
6. (c) Age of husband or wife if alive **1859** years
7. Birth date of deceased **June 1** **1859**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct 4**, 1939, to **Dec 30**, 1939
that I last saw him alive on **Dec 30**, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years **80** Months **6** Days **18**
If less than one day _____ hr. _____ min.

Immediate cause of death **Acute Dilatation of Heart**
Due to **chronic myocarditis**
Due to _____

9. Birthplace **Ill.** (City, town, or county) (State or foreign country)
10. Usual occupation **Progrman**

Other conditions **Chronic hepatitis; Iron deficiency anemia**
(Include pregnancy within 3 months of death)
Major findings: **Hyperostosis of vertebrae**
Of operations **Nbs**
Of autopsy **no**

11. Industry or business **Grocery**
12. Name **Unknown**
13. Birthplace **Unknown**
14. Maiden name **Unknown**
15. Birthplace **Unknown**

PHYSICIAN _____
Underline the cause to which death should be charged statistically

MOTHER FATHER
16. (a) Informant's own signature **Golden A. Collins**
(b) Address **913 E. Dale St. Springfield, Mo.**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Jan 3, 1940**
(c) Place: burial or cremation **Green City, Mo.**
18. (a) Signature of funeral director **Leonard Jones**
(b) Address **Buffalo, Mo.**
19. (a) **12-30-1939** (Date received local registrar) (b) **Chas. R. George, Jr.** (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **no**
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Walter Samell** (M. D. or other) **MD**
Address **Springfield Mo** Date signed **12.30.39**

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..... *William J. Hay*
Licensed Embalmer No..... *4071*
P.O. Address..... *Springfield*

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.