

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.

STANDARD CERTIFICATE OF DEATH

36155

State File No.

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 188

1. PLACE OF DEATH

(a) County Randolph  
 (b) City or town Moberly  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
212 N. Ault St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)  
 In this community \_\_\_\_\_  
 years, months or days

8. (a) PRINT FULL NAME William Collins  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race col 6. (a) Single, widowed, married, divorced Divorced  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 5-12-1876  
 (Month) (Day) (Year)

8. AGE: Years 64 Months 3 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Unknown

11. Industry or business \_\_\_\_\_

12. Name Unknown

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name Mancy Hughes

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant's own signature Fannie C. Davis

(b) Address Moberly, Mo.

17. (a) Burial (b) Date thereof 9 12 40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation no

18. (a) Signature of funeral director C. P. Carr

(b) Address 417 N. 5th St

19. (a) 9/11/40 (b) Seal Hulse  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Randolph  
 (c) City or town Moberly  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 212 N. Ault St  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day Sept  
 year 1940 hour 4 minute 10 M.

21. I hereby certify that I attended the deceased from 1938  
 \_\_\_\_\_, 1938, to Sept 10, 1940  
 that I last saw him alive on Sept 5-11, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocardite  
 Duration 7 yr

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy no

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

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?  
 \_\_\_\_\_  
 \_\_\_\_\_ (Specify type of place)  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature W. A. Mangel (M. D. or other) \_\_\_\_\_  
 Address Moberly, Mo. Date signed 9/11/40

RECEIVED

District Health Officer No. 10

District File Number 10-40-1980

Date Filed OCT 24 1940

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 Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Moberly Mo.

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.