

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

36287

State File No. _____

Registration District No. 284

Primary Registration District No. 101

Registrar's No. 1924

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution:
St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day 14 hr. 10 min.
(Specify whether years, months or days)
In this community 11 years

3. (a) PRINT FULL NAME Camille Colin

3. (b) If veteran, name war ? 3. (c) Social Security No. ?

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Fanny Hamilton Colin 6. (c) Age of husband or wife if alive ? years
7. Birth date of deceased Jan. 24 1867
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 15 If less than one day
hr. min.

9. Birthplace Unknown Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation nil.

11. Industry or business _____

MOTHER FATHER { 12. Name Emil Colin
13. Birthplace Unknown France
(City, town, or county) (State or foreign country)
14. Maiden name Mary Ann Walker
15. Birthplace Unknown S. Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Fanny Colin
(b) Address 3734 Marvin Ave.

17. (a) Removal (b) Date thereof 10-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fun Home, Mo.

18. (a) Signature of funeral director Robert H. Happe

(b) Address 4700 Washington Ave.

19. (a) OCT 11 (b) R. M. M. D. D. D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis
(c) City or town Overland
(If outside city or town limits, write "RURAL")
(d) Street No. 3734 Marvin Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 9
year 1940 hour 10 minute :30 P. M.

21. I hereby certify that I attended the deceased from 10-8-40
to 10-9-40, 19____, to 10-9-40, 19____;
that I last saw him alive on 10-9-40
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion Duration 5 da.

Due to 94%

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy Infarct in region of descending branch of Pott. coronary Artery -

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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 A. H. Forman Jr. Address St. Louis Co. Hosp. Date signed 10/19/40

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.....

Albert G. Hoppe

Licensed Embalmer No.....

2971

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, fact should be so stated above.