

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

1096

Registration District No.

399

Primary Registration District No.

1002

Registrar's No.

56

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
K. C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether life)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME JESSIE COLLINS

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Robert Collins 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 17 1881  
(Month) (Day) (Year)

8. AGE: Years 59 Months 7 Days 15 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation nurse

MOTHER FATHER

12. Name Isaac Odelle  
13. Birthplace Johnson Co. Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Ann Morrow  
15. Birthplace Johnson Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant A. J. Byerly

(b) Address Warrensburg - Mo.

17. (a) Burial (b) Date thereof Jan 4 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Warrensburg

18. (a) Signature of funeral director Sweeney Phillips

(b) Address Warrensburg, Mo.

19. (a) Jan 6 1941 (b) M. J. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson US  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 317 West 13th St.  
(If rural, give location) 0  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 2nd  
year 1941 hour 4:00 A.M. minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 1-1-41, 19\_\_\_\_, to 1-2-41, 19\_\_\_\_;  
that I last saw her alive on 1-2-41, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebellar Hemorrhage

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

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

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

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy See above

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 Drury R. Thoria (M. D. or other) \_\_\_\_\_  
Address Med. Dir. K.C. Gen. Hospital, K.C. Mo. Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**