

7225

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 4408

Primary Registration District No. 3020

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Jasper
(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mc Lane Brooks Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Three Days
(Specify whether
In this community 11 years
years, months or days)

8. (a) PRINT FULL NAME John Collings

8. (b) If veteran, name war None 8. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Single

6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive Unknown

7. Birth date of deceased 1870
(Month) (Day) (Year)

8. AGE: Years 71 Months - Days - If less than one day - hr. - min.

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

10. Usual occupation Laborer

11. Industry or business None

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mc Lane Brooks Hospital Records
(b) Address Carthage Mo.

17. (a) Burial (b) Date thereof Feb 26, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dale Hill Cemetery

18. (a) Signature of funeral director Huell Mortuary
(b) Address Carthage Mo.

19. (a) Feb 26, 1941 (b) E. J. McIntire, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 49
(c) City or town Carthage 1
(If outside city or town limits, write "RURAL") 3
(d) Street No. 315 N Maple
(If rural, give location)
(e) If foreign born, how long in U. S. A? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22
year 1941 hour 3:00 pm minute - M.

21. I hereby certify that I attended the deceased from 2/17
1941 to 2/22 1941
that I last saw him alive on 2/22 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Unknown
Duration

Due to
Due to

Other conditions Spasmodic 3 Days
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy
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)
(b) Date of occurrence
(c) Where did injury occur? 865
(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 J. J. Mc New (M. D. or other) M.D.
Address Carthage Date signed Feb

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

19
1
3

41-3-278

83A

STATE OF MISSISSIPPI
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

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 John D. Batchelder

Licensed Embalmer No. 4153

P. O. Address Carthage 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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

7225-
Do not use this space.

1. PLACE OF DEATH
(a) County Jasper Registration District No. 408
(b) Township _____ Primary Registration District No. 3020 Registered No. _____
(c) City Carthage (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 John 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 w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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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. _____
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) _____

FATHER 13. NAME _____

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

MOTHER 15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19.

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED _____ 19. _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22 1941

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Myocardia due to chronic hepatitis
12/18
Date of onset _____

Other contributory causes of importance:
semipleurisy due to cerebral hemorrhage
Date of onset 2/15/41

Name of operation _____ Date of _____
What test confirmed diagnosis? clinical 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? _____
If so, specify _____
(Signed) W. B. McCreary, M. D.
(Address) Carthage, Mo.

SUPPLEMENT

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

Local Registrar.

