

FILED APR 8 1941

Registration District No. **87947** Primary Registration District No. **3039**

Registrar's No. **97**

1. PLACE OF DEATH:

(a) County Vernon
 (b) City or town Nevada
 (c) Name of hospital or institution: 629 N. Olive
 (d) Length of stay: In hospital or institution 5 mo 13 da
 In this community 5 mo 13 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Vernon
 (c) City or town Nevada
 (d) Street No. 629 N. Olive
 (e) If foreign born, how long in U. S. A. 0 years

3. (a) PRINT FULL NAME Charles T. Isaac Collins

(b) If veteran, name war no (c) Social Security No. none

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced single

(b) Name of husband or wife _____ (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 22, 1940

8. AGE: Years 0 Months 5 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Nevada, Mo

10. Usual occupation none

11. Industry or business none

12. Name Charles Collins

13. Birthplace Evanville, Ill

14. Maiden name Carpis

15. Birthplace Mt. Vernon, Mo

16. (a) Informant Charles Collins

(b) Address Nevada, Mo

17. (a) Burial (b) Date thereof 3/17/41

(c) Place: burial or cremation Worse Cemetery

18. (a) Signature of funeral director Ferry Funeral Home

(b) Address Nevada, Mo

19. (a) _____ (b) _____

MOTHER FATHER

108
1
2

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 15, year 1941 hour 10:30 minute A M.

21. I hereby certify that I attended the deceased from Mar 14, 1941 to Mar 15, 1941 that I last saw him alive on Mar 14, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Robas Pneumonia Duration 2 days

Due to following - Influenza 1 wk.

Other conditions ✓ (Include pregnancy within 3 months of death) 3 2 4

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? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ While at work? NO (Specify type of place) _____ (e) Means of injury _____

23. Signature W. L. Love (M. D. or other) MD
Address Nevada, Mo Date signed 3/18/41

RECEIVED

District Health Officer No. 7,

District File Number 4-41-639

Date Filed 4-8-41

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.....

Lloyd R. Winsett

Licensed Embalmer No. 3857

P. O. Address Murphy, 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.

Registration District No. 875

Primary Registration District No. 3039

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Vernon Nevada
(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(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

3. (a) PRINT FULL NAME

Charles T. Isaac Collins

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years Months Days If less than one day
5 13 _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/27/41 (b) Allen V. Lays
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Mar day 15
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 W.S. Howe (M. D. or other) _____

Address Nevada mo Date signed _____

SUPPLEMENTAL

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

