

13-40
7-39
X23189

FILED OCT 13 1941

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH: **Jackson**
 (a) County **Kansas**
 (b) City or town **City**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution **General Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **27 days**
 In this community **About 38 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jackson**
 (c) City or town **Kansas City**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **1015 E. 29th**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. **✓** years.

3. (a) PRINT FULL NAME **RAY DIXON COLLINS**
 3. (b) If veteran, name war **none**
 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **September** 26th day
 year **1941** hour **3:40** minute **A.** M.

4. Sex **male** 5. Color or race **white**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Myrtle S. Collins**
 6. (c) Age of husband or wife if alive **58** years
 7. Birth date of deceased **July 31, 1881**
 (Month) (Day) (Year)
 8. AGE: Years **60** Months **1** Days **26**
 If less than one day hr. min.

21. I hereby certify that I attended the deceased from **Aug. 31st**, 19**41**, to **September 26**, 19**41**;
 and that death occurred on the date and hour stated above.
 that I last saw h **im** alive on **September 26, 1941**.
 Immediate cause of death **Ischaemic prothrombotic gangrenous cystitis** Duration
Hypertensive Heart Disease
 Due to **Recent transurethral resection**

9. Birthplace **Keokuk Iowa**
 (City, town, or county) (State or foreign country)
 10. Usual occupation **Presser**
 11. Industry or business **Tailor Shop**
 MOTHER FATHER {
 12. Name **Harry Collins**
 13. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)
 16. (a) Informant **Myrtle S. Collins**
 (b) Address **1015 East 29th**
 17. (a) **Burial** (b) Date thereof **Oct. 30 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Forest Hill Cemetery**
 18. (a) Signature of funeral director **John Stone**
 (b) Address **340 North 29th Street**
9/29/41 (b) **M. N. Crow** K.C.K.
 (Date received local registrar) (Registrar's signature)
 19. (a) (b)

Due to.....
 Other conditions (include pregnancy within 3 months of death)
 Major findings: Of operations **see above**
 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) (c) Means of injury
 23. Signature **Dwight R. Howard** (M. D. or other)
 Address **1015 E. 29th St. Kansas City, Mo.** Date signed **9/29/41**

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

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

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:.....

Amelia Stone

Licensed Embalmer No. *4113*

P. O. Address

*340 North Sixth
R. C. 1*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3612

1. PLACE OF DEATH:

(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Childrens Mercy Hospital
(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 Ray Dixon Collins

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

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

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

10. Usual occupation

11. Industry or business

MOTHER { 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)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (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. 1015 E. 29th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: month Sept. day 26th
year 1941 hour minute M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw him alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Ascending pyelonephritis
gangrenous cystitis-hypertensive heart disease

Due to Recent transurethral resection for Benign Adenomatous Prostatic hyperplasia.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Yes

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 (Specify type of place) (Specify means of injury)

23. Signature Wm R. Shore (M. D. or other)
Address Med. Dir. K. C. Gen. Hospital Date signed

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

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 3612

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: General Hospital
(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 Ray Dixon Collins

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

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

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 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3/28/42 (b) M. H. Crome
(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) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 26 year 1942 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 Ascending pyelonephritis
gangrenous cystitis
hypertensive heart disease
Renal transurethral resection

Due to _____
Due to _____ 137b

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

Major findings: Prostatic Benignumor
Of operations 9/23/41
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? _____
(Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____