

FILLED NOV 24 1941

State File No. _____

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **8313**

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Christon Hospital. 0
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 day**
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME **CATHERINE J. COLLINS.**

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

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

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

7. Birth date of deceased **December 29 1877**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	63	9	19hr.min.

9. Birthplace **St. Louis Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Milliner.**

11. Industry or business _____

MOTHER FATHER { 12. Name **William Collins.**

13. Birthplace **? Ireland. //**
 (City, town, or county) (State or foreign country)

14. Maiden name **Anna Mayles**

15. Birthplace **? England. U**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Anna Cleghorn.**

(b) Address **2030a Alice Ave.**

17. (a) **Burial** (b) Date thereof **Oct. 20, 1941**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery.**

18. (a) Signature of funeral director **Geo. L. Pleitsch Inc.**

(b) Address **5966 Easton Ave**

19. (a) **OCT 20 1941** (b) **J. J. Brudeck**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
 (c) City or town **St. Louis.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **2030a Alice Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **17**
 year **1941** hour **4** minute **55** P. M.

21. I hereby certify that I attended the deceased from **Sept 15**
 19**41** to **Oct 17** 19**41**
 that I last saw her alive on **Oct 17** 19**41**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Diabetes Mellitus** Duration **Several months**

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) _____
 (Means of injury) _____

23. Signature **Walter J. Mullies** (M. D. or other) _____

Address **3825 N 70th** Date signed **10/18/41**

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

1-28-88 - 8-28-88
C. F. 6780

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 3454

David C. Gibson

Registered Apprentice No. _____

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 5966 Easton St.

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.