DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41955

FILED JAN 16 1942

Registration District No. 218 Primary Registration District No. 2001 Registrar's No.

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

1. PLACE OF DEATH:
(a) County Green
(b) City or town Springfield, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John Hosp'l (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Green 29
(c) City or town Springfield 2 (If outside city or town limits, write "RURAL")
(d) Street No. 710 West Elm 6 (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Weltha Jane Collins
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F 1
5. Color or race W.
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March 2nd 1900 (Month) (Day) (Year)

8. AGE: Years 41 Months 10 Days 8 If less than one day hr. min.

9. Birthplace Christian Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Clerical
11. Industry or business
FATHER
12. Name Horace Collins
13. Birthplace Christian Missouri (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Daisy McKinnis
15. Birthplace Christian Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Daisy Collins
(b) Address Springfield Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 12 42 (Month) (Day) (Year)
(c) Place: burial or cremation Selmore
18. (a) Signature of funeral director T. B. Chaffin
(b) Address Ozark Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 10th year 1942 hour 3 minute 15 P.M.
21. I hereby certify that I attended the deceased from Feb 2 1939, to 19 ; that I last saw her alive on Jan 10 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Sclero Lerma	6 years
Arthritis Deformans	6 years
Due to	
Due to	
Other conditions Raynaud disease (Include pregnancy within 3 months of death)	7 years

Major findings:
Of operations none
Of autopsy 99.2

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) No
(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 E. E. Gilbert (M. D. or other)
Address Springfield Mo. Date signed 1/14/42

484 (Licensed Embalmer's Statement on Reverse Side)

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.....T. B. Chaffin.....

Licensed Embalmer No.....2192.....

P. O. Address.....Ozark, 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, fact should be so stated above.

. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41955

Registration District No. 314 Primary Registration District No. 2001 Registrar's No. 26-A

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Johns (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 days (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Willha J. Collins
3. (b) If veteran, name war —
3. (c) Social Security No.
4. Sex F
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 Mar. (Month) 2 (Day) 1900 (Year)
8. AGE: Years 41 Months 10 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
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 1-31-42 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature) By O.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 10 year 1942 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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? (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

SUPPLEMENTARY