

No. 2
-5-42
5-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39613

State File No.

FILED DEC 28 1942

Registration District No. Primary Registration District No. 1002 Registrar's No. 4668

1. PLACE OF DEATH

(a) County Jackson
(b) City or town Jackson City
(c) Name of hospital or institution 709 Washington
(d) Length of stay: In hospital or institution
In this community unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(d) Street No. 709 Washington
(e) Citizen of foreign country? unknown

4638

3. (a) PRINT FULL NAME: JOHN C. COLLINS

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

4. Sex Male 5. Color of race W 6. (a) Single, widowed, married, divorced unknown

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

7. Birth date of deceased unknown

8. AGE: Years about 70 yrs Months Days If less than one day hr. min.

9. Birthplace unknown

10. Usual occupation

11. Industry or business

12. Name unknown

13. Birthplace unknown

14. Maiden name

15. Birthplace unknown

16. (a) Informant Coroners office

(b) Address 1000 Mo

17. (a) Date there of 12/15/42 (b) Date there of (Month) (Day) (Year)

(c) Place of burial or cremation 1000 College Calverton

18. (a) Signature of funeral director

(b) Address 1000 Mo

19. (a) 12-15-42 (b) M. M. Crowe (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9th year 1942 hour 8 minute 05 AM

21. I hereby certify that attended the deceased from

that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death: Arteriosclerotic heart

Due to: Disease

Due to: 93.5

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

Major findings: Of operations

Of autopsy: Inspection history

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: M. M. Crowe (M.D. or other) Date signed: 12/15/42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 _____

Licensed Embalmer No. 44723

P. O. Address KCMo

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.