

Registration District No. **818** Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County St. Louis, Mo
 (b) City or town St. Louis, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: BARNES HOSPITAL
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1-19-43 to 1-29-43
 (Specify whether _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State ILLINOIS (b) County FRANKLIN
 (c) City or town ZIEGLER
 (If outside city or town limits, write "RURAL") N.R.
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No)
 If yes, name country. 2

3. (a) PRINT FULL NAME John Granville Collier
 3. (b) If veteran, name war No
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 29
 year 1943 hour 2 minute 55 A. M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Jennette Collier
 6. (c) Age of husband or wife if alive 60 years
 7. Birth date of deceased February 11, 1880
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 1-19-43, 19____, to 1-29-43, 19____;
 that I last saw him alive on 1-29-43, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
62 11 18 _____ hr. _____ min.

Immediate cause of death	Duration
<u>Acute pulmonary edema</u>	<u>2 days</u>
<u>Post operative shock</u>	<u>"</u>
<u>Carcinoma rt. kidney</u>	<u>2 yrs</u>

Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations Carcinoma kidney (rt)
 Of autopsy Pulm. edema

9. Birthplace City of Tazewell County, Benton Tenn
 (City, town, or county) (State or foreign country)
 10. Usual occupation Coal miner

11. Industry or business _____
 12. Name JOHN Collier
 13. Birthplace Tazewell, Benton Co. Tennessee
 (City, town, or county) (State or foreign country)
 14. Maiden name Elinora Brack
 15. Birthplace Danville, Houston Co. Tennessee
 (City, town, or county) (State or foreign country)

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

16. (a) Informant Jennette Collier (wife)
 (b) Address 412 S. Pine, Ziegler, Illinois
 17. (a) Removal (b) Date thereof Jan 30 43
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Burial at Home, Ill
Storrie Funeral Home
 18. (a) Signature of funeral director _____
 (b) Address Herrin, Illinois
 19. (a) JAN 30 1943 (b) J. F. Bredeck
 (Date received local registrar) (Registrar's signature)

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 Chas. G. Lockhart (M. D. or other) _____
BARNES HOSPITAL
 Address _____ Date signed 1/29/43

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

William J. Adams

Licensed Embalmer No.

4319

P. O. Address

St. Louis, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 963

1. PLACE OF DEATH:

(a) County _____
(b) City or town. St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Barnes 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Franklin
(c) City or town Ziegler
(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 John Granville Collier

3. (b) If veteran, name war _____ (c) Social Security N342-03-8129

4. Sex _____ 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 _____ year _____

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

8. AGE: Years _____ 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) 1-30-43 (b) J.F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Jan. day 29th
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that 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 _____

Duration

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) (e) Means of injury _____

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

Address _____ Date signed _____

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

SUPPLEMENTARY

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