

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6749**

Registration District No. **172**

Primary Registration District No. **3034**

Registrar's No. **12**

1. PLACE OF DEATH:

(a) County **Lafayette**

(b) City or town **Higginsville**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **/**
(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 **Missouri** (b) County **Lafayette**

(c) City or town **Higginsville, Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Thomas Louis Collins**

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

4. Sex **Male** 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 alive _____ years

7. Birth date of deceased **Oct 17th 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

3 22 hr. min.

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

10. Usual occupation **NONE**

11. Industry or business _____

12. Name **Wm. Louis Collins**

13. Birthplace **Higginsville, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Marion Grogan**

15. Birthplace **Peoblo, Colo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **William L. Collins**
(b) Address **Higginsville, Mo.**

17. (a) **Burial** (b) Date thereof **9/11/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Higginsville, Mo.**

18. (a) Signature of funeral director **A. H. Hader**

(b) Address **Higginsville, Mo.**

19. (a) **2-12-1943** (b) **Dr. W. A. Braetler**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **10** year **1943** hour _____ minute _____ P.M.

21. I hereby certify that I attended the deceased from **Feb 7, 1943** to **Feb 10, 1943** that I last saw him alive on **Feb. 10, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial Pneumonia** Duration **3 days**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **/**

23. Signature **E. M. Moore** (M. D. or other) **M.D.**

Address **Higginsville, Mo.** Date signed **2-12-43**

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

MOTHER FATHER

1197

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-5-43

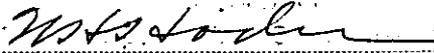
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No.

4269

P. O. Address

Higginsville, 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. 6749

Registration District No.

Primary Registration District No. 3034

Registrar's No.

1. PLACE OF DEATH: Lafayette
 (a) County Lafayette
 (b) City or town Higginville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution
(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 Thomas C Collins
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased Oct 17 - 1942
(Month) (Day) (Year)

8. AGE: Years _____ Months 3 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State mo (b) County Lafayette
 (c) City or town Higginville
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Bronchial pneumonia 3Q
 Due to _____
 Due to no complications

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations _____
 Of autopsy _____

107

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

