

FILED JUN 7 1943
Registration District No. 199

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2-23-43-4-23-43
(Specify whether years, months or days)

In this community 26 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1606 Forest 8
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME JAMES COLLINS

3. (b) If veteran, name war Don't know

3. (c) Social Security No. 6291 709-12-6291

4. Sex male 2 5. Color or race Negro

6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Verse Collins

6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased February 26 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>1</u>	<u>28</u>	hr. _____ min. _____

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

10. Usual occupation unemployed

11. Industry or business _____

MOTHER FATHER

12. Name James Collins

13. Birthplace Pa.
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Broddia

15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk

(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof 5-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Blue Ridge Lawn K.C. Mo

18. (a) Signature of funeral director [Signature]

(b) Address 1819 E. 15th K.C. Mo

19. (a) 5-3-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1943 hour 5:30 minute 0 P. M.

21. I hereby certify that I attended the deceased from February 23 1943 to April 23 1943
that I last saw him alive on April 23 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Inanition

Due to Syphilitic Hepatitis

Due to _____

Other conditions 204
(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)

23. Signature [Signature] (M. D. Registrar)

Address Gen. Hosp. 22-601 E. 22 Date signed 4-23-43

1750-51-901

10-11-1951

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 *Wm. G. Flynn*

Licensed Embalmer No. *2211*

P. O. Address *1819 E. 15th*

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.