

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27278  
3684  
Registrar's No. \_\_\_\_\_

SEP 7 1943  
Registration District No. 149

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 8-18-43-8-23-43  
(Specify whether years, months or days) 22 years

3. (a) PRINT FULL NAME OLIVER COLLINS  
3. (b) If veteran, name war None  
3. (c) Social Security No. 496-01-5398

4. Sex male  
5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Beulah Collins  
6. (c) Age of husband or wife if alive 30 years  
7. Birth date of deceased: December 20 1900  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
42 8 3 hr. min.

9. Birthplace: Blackburn Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation: Night Watchman

11. Industry or business: Commerce Carb Co

MOTHER FATHER

12. Name: Grant Collins

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

14. Maiden name: Birdie Katie Coxe

15. Birthplace: Missouri  
(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: 8/27/43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Lincoln Cemetery

18. (a) Signature of funeral director: Watkins Bros.  
(b) Address: 1729 Lydia Avenue

19. (a) Aug 26 1943 (b) J. E. Brown, Reg.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2226 Harrison  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 23  
year 1943 hour 4:47 minute a. M.

21. I hereby certify that I attended the deceased from August 18 19 43 to August 23 19 43  
that I last saw him alive on August 23 19 43  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumococccic Meningitis

Due to \_\_\_\_\_  
Due to gla

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)  
(c) Means of injury \_\_\_\_\_  
23. Signature: J. E. Brown (M.D. or other)  
Address: Gen. Hosp. #2-600 & 22 Date signed: 8-25-43

**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..... *Isaac J. Malone* .....

Licensed Embalmer No. *3954* .....

P. O. Address. *2503 Highland* .....

**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.**