

S. No. 2
M-1-4-41
v. 5-17-39

X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF HEALTH

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28116**
Registrar's No. **64**

Registration District No. **101**

Primary Registration District No. **5409**

1. PLACE OF DEATH:

- (a) County **Douglas**
(b) City or town **Flat Rock Rural**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Miller & Sons**
(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

Paul Collins

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

4. Sex **Male** 5. Color or race **W** 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 **11-7-1928**
(Month) (Day) (Year)

8. AGE: Years **16** Months **9** Days **6** If less than one day _____ hr. _____ min.

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

10. Usual occupation **School girl**

11. Industry or business

12. Name **Paul Collins**
13. Birthplace **Douglas Co. Mo.** (City, town, or county) (State or foreign country)
14. Maiden name **Heiter Boone**
15. Birthplace **Douglas Co. Mo.** (City, town, or county) (State or foreign country)

16. (a) Informant **Paul Collins**
(b) Address **Willow Springs Mo.**
17. (a) **Flat Rock** (b) Date thereof **8-15-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation _____
18. (a) Signature of funeral director **None**
(b) Address _____
19. (a) **9-14-43** (b) **G.E. Smith**
(Date received local registrar) (Registrar's signature)

Thelma S. Watijo 56 (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) State **Mo** (b) County **Douglas**
(c) City or town **Flat Rock Rural**
(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 **Aug** day **13** year **1943** hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from **Aug 1st** 19**43** to **Aug 13** 19**43**
that I last saw her alive on **Aug 7** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **urine poisoning**

Due to **pyelitis**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **1330**

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 **S. J. Brown** (M.D. or other)
Address **Willow Springs Mo.** Date signed _____

RECEIVED

District Office No. 31

District File Number 943-1015

Date Filed 9-9-43

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.

P. O. Address.....

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.