

FILED MAY 3 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 3017

Registrar's No. 65

1. PLACE OF DEATH:

(a) County COOPER  
(b) City or town BOONVILLE  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
415 HIGH STREET (REAR)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community LIFE years, months or days

3. (a) PRINT FULL NAME MILFORD COLLINS

3. (b) If veteran, name war NONE  
3. (c) Social Security No. 495-07-6086

4. Sex MALE  
5. Color or race NEGRO  
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS MILFORD COLLINS  
6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased NOVEMBER 21 1902  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
41 4 29 hr. min.

9. Birthplace SALINE COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business GARAGE

12. Name JOSEPH COLLINS

13. Birthplace COOPER COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

14. Maiden name BETTY SPEARS

15. Birthplace SALINE COUNTY MISSOURI  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS MILFORD COLLINS  
(b) Address BOONVILLE, MISSOURI

17. (a) BURIAL (b) Date thereof APRIL 22 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director STEGNER & KOENIG  
(b) Address BOONVILLE, MO.

19. (a) Apr 19-44 (b) Prchas. Swap  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COOPER  
(c) City or town BOONVILLE  
(If outside city or town limits, write "RURAL")  
(d) Street No. 415 HIGH STREET (REAR)  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 19th  
year 1944 hour 7:15 minute P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular

Due to Excessive drink

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

Other conditions (Include pregnancy within 3 months of death) 3rd

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 H. J. Francis (M. D. or other) OC.

Address 404 Main Boonville, Mo. Date signed 4/20/44

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1089

Mo.

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

5-2-44

MAR 19 1949

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

*James W. Stegner*

Licensed Embalmer No.

3780

P. O. Address

*Boonville, 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.