

FILED NOV 15 1944

Registration District No. 318

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

Primary Registration District No.

32155

State File No.

9430

Registrar's No.

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Margaret Collins

3. (b) If veteran, name was None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife John Collins 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 26 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 2 8 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James Busby
13. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Dora Roderman
15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant John Collins
(b) Address 4544 Flad Ave.
17. (a) Burial (b) Date thereof 11-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) NOV 6 1944 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Madison
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4544 Flad Ave.
(If rural, give location) 17
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4
year 1944 hour 5:15 minute P. M.

21. I hereby certify that I attended the deceased from Oct 10-44
_____ 19, to Nov 4 1944
that I last saw her alive on Nov 4
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Duration _____
Due to 93
Due to _____

Other conditions Abdominal tumor
(Include pregnancy within 3 months of death)
Major findings: of unknown origin as patient was inoperable PHYSICIAN _____
Of operation _____
Of autopsy None 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 R. H. Gland (M. D. or other) _____
Address 3901 Park Ave Date signed Nov 6-44

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.

emb. cert. filed separately

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.