

Registration District No. **333**

Primary Registration District No. **3074**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Scott**
 (b) City or town **Sikeston, Mo.**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Sikeston General Hospital**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Two weeks**
 In this community **about 35 Years**
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **New-Madrid**
 (c) City or town **Morehouse, Mo.**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **No.** (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **David Crockett Collier**
 3. (b) If veteran, name war **X** 3. (c) Social Security No. **X**

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **widowed**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **1 28 1869**
 (Month) (Day) (Year)

8. AGE: Years **75** Months **10** Days **12** If less than one day
 hr. _____ min. _____

9. Birthplace **Pope Co. Ill**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Asa Collier**
 13. Birthplace **Ala.**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Caroline Dees**
 15. Birthplace **Fredicktown, Mo.**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Betty Lou Collier**
 (b) Address **Morehouse, Mo.**

17. (a) **Burial** (b) Date thereof **12/12/44**
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Sikeston, Mo.**

18. (a) Signature of funeral director **John Albritton**
 (b) Address **Sikeston, Mo.**

19. (a) **1/19/45** (b) **Louise Largent**
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **10**
 year **1944** hour **5** minute **15** A.M.

21. I hereby certify that I attended the deceased from **12-1**
 19**44** to **12-10** 19**44**
 that I last saw him alive on **12-10** 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary Hemorrhage**

Duration **10 day**

Due to _____

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

Major findings: Of operations _____
 Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **L. J. Sarno M.D.** (M. D. or other) _____
 Address **Morehouse, Mo.** Date signed **1/19/45**

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

RECEIVED
District Health Office

District File Number 145

Date Filed 1-20-45

5761 52 NOV 25 1945

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

Embalmed _____, Registered Apprentice No. _____
working under my personal supervision.

Signed *John A. Sikeston*

Licensed Embalmer No. 2941

P. O. Address Sikeston, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(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 David C. Collier

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Jan 28 (Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days _____ (Unless than one day _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 Feb year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia

emphysema
Blough Condition

Due to _____ Duration _____

Due to 562

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

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 Wolhouse (M. D. or other) _____

Address Wolhouse Date signed 1-24-45

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

13
43
X36930

3728