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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11102

FILED MAY 3 1945

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3692

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:
Homer G. Phillips Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 Hrs. 15 Mins. (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17
(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")
(d) Street No. 4029 Aldine 11
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Ronald Collins – Twin 2

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

4. Sex Male 9
5. Color or race Negro
6. (a) Single, widowed, married, divorced 0
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased 4 (Month) 5 (Day) 45 (Year)

8. AGE: Years | Months | Days | If less than one day 5 hr. 15 min.

9. Birthplace St. Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation
11. Industry or business

FATHER
12. Name Sidney Collins
13. Birthplace Friars Point Mississippi 1 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillie Mae McGee
15. Birthplace Belen Mississippi 1 (City, town, or county) (State or foreign country)

16. (a) Informant Mary T. Duvall
(b) Address 2601 N. Whittier Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof APR 26 1945 (Month) (Day) (Year)
(c) Place: burial or cremation CITY CEMETERY

18. (a) Signature of funeral director V. B. Hudson
(b) Address City Health Dept

19. (a) APR 25 1945 (Date received in registrar's office) (b) J. J. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 6 year 1945 hour 4 minute 10 A. M.

21. I hereby certify that I attended the deceased from 10:55 P.M. 4 - 5 1945 to 4:10A.M. 4-6 1945 that I last saw him alive on 4 - 6 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity | Duration
Due to Unknown
Due to Unknown
Other conditions
(Include pregnancy within 3 months of death)
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? (Specify type of place)
While at work? (e) Means of injury
Signature W. J. Winkler (M. D. or other)
Address 2601 N. Whittier Date signed 4-26-45

(Licensed Embalmer's Statement on Reverse Side)

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, above space should be left blank.