

FILED MAY 24 1945
Registration District No. **301**

Primary Registration District No. **4450**

Registrar's No. **2037**

1. PLACE OF DEATH:
(a) County **RIPLEY**
(b) City or town **DONIPHAN**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
WILLIAMS HOSPITAL.
(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 **NANCY ANN WCOLLINS.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **9**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **FEB. 25- 1885.**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 2 2 hr. min.

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

10. Usual occupation **At HOME**

11. Industry or business _____

12. Name **WILLIAM FREEMAN,**
13. Birthplace _____ (City, town, or county) **NO. CAROL** (State or foreign country)
14. Maiden name **EVANS**
15. Birthplace: _____ (City, town, or county) **TENNESSEE!** (State or foreign country)

16. (a) Informant **CHAS. E. COLLINS,**
(b) Address **FREMONT, MO.**

17. (a) BURIAL (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation **WILDERNESS, MO.**

18. (a) Signature of funeral director **F. E. JORDAN,**
(b) Address **DONIPHAN, MO.**

19. (a) **5-21-45** (b) **E. D. Johnston**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Ripley 91**
(c) City or town **Wilderness community.** (If outside city or town limits, write "RURAL") **0**
(d) Street No. _____ (If rural, give location) **0**
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **APRIL** day **27.**
year **1945.** hour **9** minute **9/** M.

21. I hereby certify that I attended the deceased from **April 2, 1945, to April 27, 1945**
that I last saw her alive on **April 27-45** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral Embolism**
Fractured hip!
Due to _____
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? **at Home** (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) (e) Means of injury _____

23. Signature **J. E. Johnston** (M. D. or other) **M. D.**
Address **DONIPHAN, MO.** Date signed _____

674

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

MOTHER FATHER

JAN 27 1949

MAY 28 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.....

working under my personal supervision.

Registered Apprentice No.....

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.

17925

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17920Registration District No. 301Primary Registration District No. 4450

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Ripley
(b) City or town Doniphan
(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 NAMENancy Ann Collins3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex F5. Color or
race W6. (a) Single, Widowed, Married,
divorced Widowed6. (b) Name of husband or wife
Not Given6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased Feb '25
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

60

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director

(b) Address

19. (a) _____ (b) _____
(Date received local registrar) (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 _____
year 1945 hour _____ minute _____ 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 _____

Duration

Due to _____

Due to _____

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?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

