DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18497

FILED MAY 16 1945

Registration District No. 3714 Primary Registration District No. 6276 Registrar's No.

1. PLACE OF DEATH:

(a) County North
(b) City or town Sheridan Township (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County North
(c) City or town Rural (If outside city or town limits, write "RURAL") 113
(d) Street No. Sheridan, Mo. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jane Collins
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 7 (Day) 1856 (Year)

8. AGE: Years	Months	Days	If less than one day
88	5	18	hr. min.

9. Birthplace Springdale (City, town, or county) Iowa (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business

MOTHER FATHER
12. Name Joseph Collins
13. Birthplace New Jersey (City, town, or county) (State or foreign country)
14. Maiden name Amanda Reed
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Jack Brogan
(b) Address Sheridan Mo.
17. (a) Rural (Burial, cremation, or removal) (b) Date thereof 3-26-45 (Month) (Day) (Year)
(c) Place: burial or cremation Parnell Cemetery
18. (a) Signature of funeral director Arch C. Dunkle
(b) Address Grant City, Mo.
19. (a) April 11 1945 (Date received local registrar) (b) Maxine Lockhart (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 3 day 25 year 1945 hour 5 minute 30 A.M.
21. I hereby certify that I attended the deceased from March 20 -, 1945, to March 25 -, 1945 - that I last saw her alive on March 24, 1945 - and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to Influenza Grippe	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations None
Of autopsy None

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

23. Signature R. G. Gordon (M. D. or other) MD
Address Maryville Date signed 3-27-45

1385

(Licensed Embalmer's Statement on Reverse Side)

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

S. No. 2
—8-43
5-17-39
I X37823

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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 Jack C Trumbo

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.

2B
45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 37 Primary Registration District No. 6276 Registrar's No.

1. PLACE OF DEATH:

(a) County North
(b) City or town Sheridan (Rural)
(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)

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

3. (a) PRINT FULL NAME Jane Collins

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct 7 (Month) (Day) 1845 (Year)

8. AGE: Years 98 Months 5 Days 0 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
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(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

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

18497