

Registration District No. **65**

Primary Registration District No. **4114**

Registrar's No.

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

1. PLACE OF DEATH: **Chariton**

(a) County **Mendon**

(b) City or town **Mendon**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days) **5 yrs**

3. (a) PRINT FULL NAME **Edward L. Collins**

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

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

6. (b) Name of husband or wife **Viola Collins** 6. (c) Age of husband or wife if alive..... **58** years

7. Birth date of deceased **Oct 24/1876**
(Month) (Day) (Year)

8. AGE: Years **68** Months **9** Days **22** If less than one day hr. min.

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

10. Usual occupation **Machine operator**
Sawing & thrashing mech.

11. Industry or business **William C Collins**

12. Name.....

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

14. Maiden name **Cassie Baker**

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

16. (a) Informant **Mrs Viola Collins**

(b) Address **Mendon Mo.**

17. (a) **Burial** (b) Date thereof **8/24/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mendon Cemetery**

18. (a) Signature of funeral director **D. L. ...**
(b) Address **Mendon, Mo.**

19. (a) **Aug 24 1945** (b) **A. L. ...**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Chariton**

(c) City or town **Mendon**
(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 **Aug** day **22**
year **1945** hour **7** minute **P** M.

21. I hereby certify that I attended the deceased from **March 14** to **Aug 22** 19**45**; that I last saw him alive on **Aug 22** 19**45**; and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
acute pulmonary embolism

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **73w**
Of autopsy.....

Duration **7 weeks**
terminal

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) Means of injury.....

23. Signature **D. L. ...** (M. D. or other)
Address **Brunswick, Mo** Date signed **8/24/45**

SEP 18 1945

REMOVED
District File No. 8
Date Filed 9-7-45

SEP 12 1945

JAN 15 1946

JAN 15 1946

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 *S. L. Shepard*

Licensed Embalmer No. *3970*

P. O. Address *Wendou 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.