

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
Registrar's No. **9148**

FILED NOV 2 1945
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **5 days**
(Specify whether

In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
Missouri

(a) State..... (b) County..... **000**
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 Street No. **4398 Olive**
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No) **0**
 If yes, name country.....

3. (a) PRINT FULL NAME **DELILAH COLLINS**

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, **Widow**

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

7. Birth date of deceased **Mar 28 1862**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **20th**
 year **1945** hour **5:15** minute..... P. M.

21. I hereby certify that I attended the deceased from **10/15/45**
 , 19..... to **10/20/45** 19.....
 that I last saw her alive on **10/20/45** 19.....
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
83 **6** **22** hr. min.

Immediate cause of death:
Arteriosclerotic Heart Disease

Due to.....
 Due to.....

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

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

10. Usual occupation **Nil.**

11. Industry or business.....

MOTHER FATHER { 12. Name **Robt Scott**

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

14. Maiden name **Lucie Mitchell**

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

PHYSICIAN

Major findings:
 Of operations.....

Of autopsy.....

Underline the cause to which death should be charged statistically.

16. (a) Informant **Lucie Ford**
 (b) Address **4398 Olive**

17. (a) **Burial** (b) Date thereof **10/24/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Fort Scott, Kansas**

18. (a) Signature of funeral director **Edith E. Ambruster**
 (b) Address **4234 Manchester**

19. (a) **OCT 23 1945** **J. F. Brediek**
(Date received local registrar) (Registrar's signature)

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?.....

23. Signature **James J. Smith** (M. D. or other) **0**
 Address **1515 Lafayette 10/22/45** signed

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

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.

Victor J. ...

Signed

Henry ...

Licensed Embalmer No. *1284*

P. O. Address *St. Louis 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.