

FILED FEB 31 1946

Registration District No. ....

Primary Registration District No. ....

1003

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

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:  
Bethesda Gen. Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... 9 months 28 days  
years, months or days)

3. (a) PRINT FULL NAME Neil Russell Collins

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M 5. Color or race W

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 Apr. 15 1945  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

9 28 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name Sidney W. Collins

13. Birthplace Maple wood mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Mary E Jenkins

15. Birthplace St. Louis mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Sidney W. Collins

(b) Address 6235 Eichelberger

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof 2 14 46  
(Month) (Day) (Year)

(c) Place: burial or cremation PARKLAWN CEMETERY

18. (a) Signature of funeral director K. LEGS HAWKER

(b) Address 4228 SO. KING'S HIGHWAY

19. (a) FEB 14 1946 (Date received local registrar)

J. F. Predeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County.....

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 6235 Eichelberger  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13  
year 1946 hour 3 45 minute P M.

21. I hereby certify that I attended the deceased from 1-31-46  
1946, to 2-13-46, 1946;  
that I last saw him alive on 2-13-46, 1946;  
and that death occurred on the date and hour stated above.

Immediate cause of death Post-operative shock

Due to DERMOID CYST at base of MESENTERY

Due to.....

Other conditions none  
(Include pregnancy within 3 months of death)

Major findings: DERMOID CYST

Of operations.....

Of autopsy.....

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 George D Mohr (M. D. or other) M.D.

Address Bethesda Gen. Hosp Date signed 2-13-46

001  
1417  
90

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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..... *Edwin D Mc Dermott*

Licensed Embalmer No. *3024*

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.**