

**FILED AUG 8 1946 STANDARD CERTIFICATE OF DEATH**

State File No. **25950**

Registration District No. **335**

Primary Registration District No. **10114**

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County **Scott**  
 (b) City or town **Oran (Rural)**  
 (c) Name of hospital or institution: **Route 1, Box 145 A**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **5 years**  
 In this community **5 years**  
 (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Nettie Collins**  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widowed**  
 6. (b) Name of husband or wife **Wm. Collins** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased **Sept. 15, 1868**  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>77</b>	<b>10</b>	<b>5</b>	hr. _____ min.

9. Birthplace **Yazoo County, Mississippi**  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_  
 12. Name **Howard Shelby**  
 13. Birthplace **Unknown**  
 14. Maiden name **Nettie (Unknown)**  
 15. Birthplace **Unknown**

16. (a) Informant **Mrs. Lula Luster**  
 (b) Address **R. 1, Box 145 A, Oran, Mo.**

17. (a) **Burial** (b) Date thereof **July 23, 1946**  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation **McMullen Cemetery**

18. (a) Signature of funeral director **F. J. Sparks**  
 (b) Address **Cape Girardeau, Mo.**

19. (a) \_\_\_\_\_ (b) **H. F. Slickman**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo** (b) County **Scott**  
 (c) City or town **Oran rural**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **R. 1, Box 145 A**  
 (If rural, give location)  
 (e) Citizen of foreign country? **No** (Yes or No)  
 If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **July** day **20**  
 year **1946** hour **6** minute **55** A.M.

21. I hereby certify that I attended the deceased **from 7/17**, 19**46**  
 that I last saw her alive on **7/17**, 19**46**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Endocarditis?**

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings:  
 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 **J. A. Chase** (M. D. or other) \_\_\_\_\_  
 Address **Oran Mo** Date signed **7/20/46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

**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..... *Frank Sparks*  
Licensed Embalmer No..... *34557*  
P. O. Address..... *Cape Girardeau*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Aug  
Registrar's No. \_\_\_\_\_

Registration District No. 335

Primary Registration District No. 6118

1. PLACE OF DEATH: Scott  
(a) County.....  
(b) City or town..... 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 Nettie Collins  
3. (b) If veteran, name war..... 3. (c) Social Security No.....

20. DATE OF DEATH: Month.....  
year 1948 hour..... minute..... M.  
21. I hereby certify that I attended the deceased from..... 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.....

4. Sex F 5. Color B 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased..... Sept 15 (Month) (Day) (Year)

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

8. AGE: Years 77 Months 10 Days 10 If less than one day hr. min.  
9. Birthplace..... (City, town, or county) (State or foreign country) Miss

Major findings:  
Of operations.....  
Of autopsy.....  
Underline the cause to which death should be charged statistically.

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..... (Month) (Day) (Year)  
(Burial, cremation, or removal) (Place: burial or cremation)  
18. (a) Signature of funeral director.....  
(b) Address.....

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) (c) Means of injury

19. (a)..... (b) G. S. Schmaed  
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

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

25900