

No. 2  
OM-8-43  
v. 5-17-39  
I X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32901**  
Registrar's No. **346**

Registration District No. **47** Primary Registration District No. **3008**

4  
1  
2  
31723  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County Callaway

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

(c) Name of hospital or institution:  
State Hosp. #1 - 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Since 4-8-43  
(Specify whether years, months or days)

**3. (a) PRINT FULL NAME** William Collins

3. (b) If veteran, name war -

3. (c) Social Security No. -

4. Sex male 5. Color or race negro

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 June 15 1891  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>55</u>	<u>4</u>	<u>10</u>	hr. min.

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

10. Usual occupation mechanic

11. Industry or business -

12. Name Wm. J. Collins

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

14. Maiden name Pearl Whitney

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

16. (a) Informant Hosp. records

(b) Address Columbia

17. (a) Columbia (b) Date thereof 10-28-1946  
(Date received for removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia MD

18. (a) Signature of funeral director J. D. Roberto

(b) Address Columbia MD

19. (a) 10-28-1946 (b) James M. ...  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Miss. State Penitentiary County Penitentiary

(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 -

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct, day 25<sup>th</sup>, year 1946 hour 10 minute 50 A. M.

21. I hereby certify that I attended the deceased from April 8<sup>th</sup> 1943 to Oct 25<sup>th</sup> 1946 that I last saw him alive on Oct 25<sup>th</sup> 1946 and that death occurred on the date and hour stated above.

Immediate cause of death Syphilitic meningitis Encephalitis (Paras)

Due to -

Due to -

Other conditions General arteriosclerosis  
(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 6

23. Signature P. S. Tate (M. D. or other)

Address State Hosp. #17 Fulton Date signed 10-25-46

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Date Filed 11/6/46

District File Number \_\_\_\_\_

District Health Officer No. 3

RECEIVED

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

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.**