

S. No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 17 1946
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **42265**
Registrar's No. **10458**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
219 E. Courtois
(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)

3. (a) PRINT FULL NAME Winifred Collins
3. (b) If veteran, name war -- **3. (c) Social Security** No. no

4. Sex female **5. Color or** race white
6. (a) Single, widowed, married, divorced widow
6. (b) Name of husband or wife Dennie Collins **6. (c) Age of husband or wife if** alive _____ years
7. Birth date of deceased December 9 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 11 25 hr. _____ min.

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

10. Usual occupation none

11. Industry or business at home

12. Name Martin Loftis
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Winifred Gallaher
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mxxx Mary F. Day
(b) Address 7821 Michigan Ave.

17. (a) burial (b) Date thereof 12-6-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Olive

18. (a) Signature of funeral director Fendler Und. Co.
(b) Address 7420 Michigan

19. (a) DEC 6 1946 (b) _____
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 7821 Michigan
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3
year 1946 hour 10 minute 30 A.M.
21. I hereby certify that I attended the deceased from 11-27
1946 to 12-4 1946
that I last saw him alive on 12-4 1946
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration 2 months

Due to Arthritis 4 years

Due to _____
Other conditions 93
(Include pregnancy within 3 months of death)

Major findings:
Of operations: _____
Of autopsy: _____
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) (e) Means of injury _____

23. Signature Charles J. Tite (M.D.)
Address 7110 Michigan Date signed 12/4/46

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
41075

File

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.....

Allen Mayfield

Licensed Embalmer No. *3077*

P. O. Address *St. James 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.