

UNITED STATES DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

FILED MAY 5 1947
Registration District No. **199**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
4415 E 9th
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution no (Specify whether
 In this community 9 mo. years, months or days)

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

4. Sex Fem 5. Color or race Wh
 6. (a) Single, widowed, married, divorced Wid.
 6. (b) Name of husband or wife John Wilson Collins
 6. (c) Age of husband or wife if alive Dec. years
 7. Birth date of deceased 2 4 1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 19
 If less than one day hr. min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business --

MOTHER FATHER 12. Name -- Bauer

13. Birthplace Germany 4
(City, town, or county) (State or foreign country)

14. Maiden name Unk.

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

16. (a) Informant A. P. Dew

(b) Address 522 Cypress

17. (a) Burial (b) Date thereof 4/26/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's Cemetery

18. (a) Signature of funeral director John P. Sheil
K. C. Mo.

(b) Address 424-47
 19. (a) 424-47 Gertrudine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson 48
 (c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
 (d) Street No. 4415 E 9th 0
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 23
 year 1947 hour 11 minute A M.
 21. I hereby certify that I attended the deceased from 10-15-1946
 _____, 19____, to April 23, 1947;
 that I last saw her alive on April 23, 1947;
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Myocarditis 10 hours
Chronic Myocarditis about 30 years

Due to _____

Due to _____

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

Major findings:
 Of operations 93

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?
(Specify type of place)

While at work? _____ (c) Means of injury 0

23. Signature J. W. Gavenburg M.D. (M. D. or other)
352 1/2 Broadway K. C. Mo. 4/24-47
Address Date signed

Dr. Gauerholtz
3527 Broadway
Before noon

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

John P. Shul

Licensed Embalmer No.

3425

P. O. Address

66 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.