No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 22 1947

MISSOURI DIVISION OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 43786

Registration District No. 377 — Primary Registration District No. 6076 — Registrar's No. 2227

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Koch
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1,687 days. (Specify whether
In this community 7½ years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 000
(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 2126a Withnell 9
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 1
If yes, name country

3. (a) PRINT FULL NAME: Collins, Charles Leslie
3. (b) If veteran, name war:
3. (c) Social Security No.: 719-12-1246
4. Sex: Male 0
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single 0
6. (b) Name of husband or wife: ---
6. (c) Age of husband or wife if alive: --- years
7. Birth date of deceased: 6-22-17 (Month) (Day) (Year)

8. AGE: Years 30 | Months 5 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace: Poplar Bluff (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: Bench Hand
11. Industry or business: Railroad
FATHER
12. Name: Leslie Melvin Collins 0
13. Birthplace: Poplar Bluff (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name: Esie Barnhill
15. Birthplace: Nashville (City, town, or county) Tenn. (State or foreign country) 1
16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-4-47 (Month) (Day) (Year)
(c) Place: burial or cremation POPLAR BLUFF MO
18. (a) Signature of funeral director: ROWLAND MORTUARY SCR
(b) Address: 4355 WASHINGTON AV
19. (a) 12-4-47 (Date received local registrar) (b) Cecil [illegible] (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month December day 2nd year 1947 hour 9 minute 30 am
21. I hereby certify that I attended the deceased from 4-20-43, 19..., to 12-2-47, 19...; that I last saw him alive on 12-2-47, 19...; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: Pulmonary Tuberculosis | 5yr (?) |
| Due to: Extra Pleural Pneumo-thorax treatment (?) | |
| Due to: | |
| Other conditions: (Include pregnancy within 3 months of death) | |
| Major findings: Of operations: | |
| Of autopsy: Confirms above. | |

PHYSICIAN — Underline the cause of 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) 0
While at work? (e) Means of injury
23. Signature: Edward [illegible] (M. D. or other) M.D.
Address: Robert Koch Hospital Date signed 12-3-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

## 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 Alex Campbell

Licensed Embalmer No. 3881

P. O. Address St Louis 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.**