S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED FEB 9 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 44525

Registrar's No. 969

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 22 days (Specify whether years, months or days)
In this community 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1109 Chestnut St.,
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANK COLLINS
3. (b) If veteran, name war Unk.
3. (c) Social Security No. Unk.
4. Sex male
5. Color or race white
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 21st (Month) Unknown (Day) (Year)

8. AGE	Years	Months	Days	If less than one day
abt -	73			hr. min.

9. Birthplace Mass. (City, town, or county) (State or foreign country)
10. Usual occupation Hotel Clerk
11. Industry or business
FATHER
12. Name John Collins
13. Birthplace Unknown (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Catherine Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof JAN 31 1948 (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board
18. (a) Signature of funeral director ROWLAND
(b) Address 4104 MANCHESTER
19. (a) JAN 31 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec. day 31st year 1947 hour 10 minute 30 A.M.
21. I hereby certify that I attended the deceased from 12/11/47, 19, to Dec. 31st 19 47, that I last saw him alive on Dec. 31st 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: carcinoma of stomach	unknown
Due to:	
Due to:	
Other conditions: metastasis to lungs (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

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)
While at work? (e) Means of injury
23. Signature Frank F. Martin (M. D. or other)
Address 1515 Lafayette 12/31/47

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.....

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.