FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED MAR 4 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3817

Registration District No. 1 — Primary Registration District No. 3000 — Registrar's No. 59

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

1. PLACE OF DEATH:
(a) County: Adair
(b) City or town: Kirksville, (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C.O.S. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 12 days (Specify whether years, months or days)
In this community: 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Adair
(c) City or town: Kirksville, Mo. (If outside city or town limits, write "RURAL")
(d) Street No.: 1507 So. Still (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Bernard Stanley Collins, Jr.
3. (b) If veteran, name war: X
3. (c) Social Security No.: X
4. Sex: Male
5. Color or race: W
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: Feb. (Month) 16 (Day) 1948 (Year)

8. AGE: Years 0 | Months 0 | Days 12 | If less than one day: hr. min.

9. Birthplace: Kirksville (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Infant
11. Industry or business:
FATHER
12. Name: Bernard Stanley Collins
13. Birthplace: Thomas (City, town, or county) West Virginia (State or foreign country)
MOTHER
14. Maiden name: Lillian Price
15. Birthplace: Athens, West Virginia (City, town, or county) (State or foreign country)
16. (a) Informant: Bernard Stanley Collins
(b) Address: Kirksville, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 2/29/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Athens, W. Va.
18. (a) Signature of funeral director: Dee Riley Funeral Home
(b) Address: Kirksville, Mo.
19. (a) 2-28-48 (Date received local registrar) (b) Kaye Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 28 year 1948 hour 3:40 minute A. M.
21. I hereby certify that I attended the deceased from Feb 16, 1948, to Feb. 28, 1948; that I last saw him alive on Feb. 28, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death: Complete atelectasis
Due to: Prematurity (6½ mo)
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 1 59
Of autopsy:

Duration

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: 2
23. Signature: [signature] (M. D. or other)
Address: KCOS Clinic Kirksville Mo. Date signed: Feb. 28, 48

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

RECEIVED
District Health Officer No.
District File Number 3-48
MAR 2 1948
Date Filed

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 William C. Mendenhall

Licensed Embalmer No. 4449

P. O. Address Kirksville, 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.

2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. [illegible]

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 59

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(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

3. (a) PRINT FULL NAME Bernard S. Collins

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb (Month) 16 (Day) 1948 (Year)

8. AGE: Years 0 Months 0 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 2-28-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Feb day 28
year 1948 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

1948
S-3817