S. No. 2
M—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUL 12 1948

Registration District No. 143

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5558

State File No. 19339

Registrar's No.

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

1. PLACE OF DEATH:
(a) County Howell
(b) City or town Pilgrim Springs Mo
(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 68 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Howell
(c) City or town Pilgrim Springs
(If outside city or town limits, write "RURAL")
(d) Street No. 46
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

3. (a) PRINT FULL NAME Alec Collins
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex Mo
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. 26 1880 (Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 4 If less than one day hr. min.
9. Birthplace Pilgrim Sprgs, Mo (City, town, or county) (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Beke Collins
13. Birthplace Unk (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Dene Collins
15. Birthplace Unk (City, town, or county) (State or foreign country)
16. (a) Informant Bert Collins
(b) Address Pilgrim Springs Mo
17. (a) B (Burial, cremation, or removal) (b) Date thereof 5-1-48 (Month) (Day) (Year)
(c) Place: burial or cremation Pilgrim Springs
18. (a) Signature of funeral director Robert Jones
(b) Address West Plains Mo
19. (a) 7-20-48 (Date received local registrar) (b) Martha Ballard (Registrar's signature) HCS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 30 year 1948 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from 19 Mar 1948 to 30 Apr 1948 that I last saw him alive on 26 Apr 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis Arteriosclerosis	
Due to	
Due to	
Other conditions (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 [illegible] (M. D. or other) M.D.
Address West Plains, Mo Date signed 4 May 48

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

381

R. [illegible]

RECEIVED 7-6-48
District Health Officer No. 5,
District File Number 148437
Date Filed 7-6-48

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.

S. No. 2B
M—3-45
I 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. July
Registrar's No. 67

Registration District No. 143
Primary Registration District No. 5558

1. PLACE OF DEATH:

(a) County Howell
(b) City or town Silom Springs
(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 years, months or days)
In this community

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 Alec 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 Wid

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 26 1880
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days If less than one day hr. min.

9. Birthplace (City, town, or county) No (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) 7/26/48 (Date received local registrar) (b) Marshalee Ballard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 30 year 1948 hour P. 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.

Immediate cause of death — Duration

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

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

SUPPLEMENTARY

S(3)-19339