

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 262101
Registrar's No. 3021

Registration District No. 149

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:
LINWOOD & TRACY MAYFAIR HOTEL 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 44 YEARS years, months or days)

3: (a) PRINT FULL NAME MR. IRVIN LEE COLLIER

3. (b) If veteran, name war No 3. (c) Social Security No. 487-03-3889

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. CHRISTINE COLLIER 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased JULY 29 1901
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 11 28 hr. min.

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

10. Usual occupation ENGINEER

11. Industry or business FAIRBANKS-MORSE & CO.

12. Name GUY COLLIER

13. Birthplace UNKNOWN KENTUCKY
 (City, town, or county) (State or foreign country)

14. Maiden name JESSIE MILLER

15. Birthplace UNKNOWN KENTUCKY
 (City, town, or county) (State or foreign country)

16. Informant Mrs Christine Collier

Address MAYFAIR HOTEL LINWOOD & TRACY

17. (a) CREMATION (b) Date thereof JULY 28 1948
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMER'S SONS

18. (a) Signature of funeral director D.W. Newcomer's Sons
 (b) Address 1401 BRUSH CREEK BLVD.

19. (a) 7-28-48 (b) Suzaldine Holmes
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County JACKSON
 (c) City or town KANSAS CITY 48
 (If outside city or town limits, write "RURAL")
 (d) Street No. LINWOOD & TRACY MAYFAIR HOTEL 3
 (If rural, give location) 8
 (e) Citizen of foreign country? No (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JULY day 26TH
 year 1948 hour 1 minute 00 P. M.

21. I hereby certify that I attended the deceased from 7-24-48 only
 _____, 19____, to _____, 19____;
 that I last saw him alive on 7-2-48, 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Duration _____

Due to Coronary insufficiency

Due to _____

Other conditions Urinary tract infection HWK
 (Include pregnancy within 3 months of death)

Major findings: Of operations None PHYSICIAN

Of autopsy None PH
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature John B. Purran (M. D. or other) _____
 Address 5515 E 127th St Date signed 7-26-48

William B. G.

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 Jess T. News
Licensed Embalmer No. 44523
P. O. Address Kansas City

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.