

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED AUG 28 1948MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 27597
Registrar's No. 6900

Registration District No. 318

Primary Registration District No. 1003

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: **En Route Homer Phillips Hosp**
3-5 South Compton Ave
(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)

3. (a) PRINT
FULL NAME

Ney Collier

3. (b) If veteran, No
name war.....

3. (c) Social Security No. No

4. Sex **Male** 2 5. Color or race **Colored**
6. (a) Single, widowed, married, divorced **Widowed** 2
6. (b) Name of husband or wife.....
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased **Not Known**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 66 hr. min.

9. Birthplace **Starkville Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business

Ney Collier

12. Name **Starkville Miss.**

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

14. Maiden name **Ellen Perkins**

15. Birthplace **Starkville, Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **3940 West Belle Pl.**

(b) Address **Burial**

17. (a) (Burial, cremation, or removal) (b) Date thereof **Aug. 6, 1948**
(Month) (Day) (Year)

(c) Place: burial or cremation **Greenwood Cemetery**

18. (a) Signature of funeral director **A. J. Beal Und Co.**

(b) Address **2726 Lucas Ave.**

19. (a) **AUG 5 - 1948** (b) **J. F. Brudeck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **St. Louis, Mo.** (b) County **600**
(c) City or town **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **5. South Compton Ave** **9**
18 (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **2nd** day **August** 19**48**
year **1948** hour..... minute **2 P.** M.

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

Immediate cause of death.....

Due to **Intestinal Perforation**
Intestinal (Homer Phillips Hospita)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy **Intestinal**

Underline the cause to which death should be charged statistically.

PHYSICIAN

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 **Robert E Taylor** (M. D. or other)

Address..... Date signed **8-5-48**

(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 Vara J. Wilson

Licensed Embalmer No. 4435

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.