

FILED OCT 4 1948

Registration District No. 442

Primary Registration District No. 1000

Registrar's No. 1015

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 day (Specify whether
 In this community 13 years. (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Nellie Day Collins

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife James E. Collins 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased May 19 1867
(Month) (Day) (Year)

8. AGE: Years 81 Months 4 Days 4 If less than one day
 hr. _____ min. _____

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

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER
 { 12. Name Henry V. Day
 { 13. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mary Colwell
 { 15. Birthplace Unknown Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cleone C. Glick

(b) Address 2837 Messanie St., St. Joseph, Mo.

17. (a) Removal (b) Date thereof Sept. 25, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kansas City, MO.

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1946 Colman St., St. Joseph, Mo.

19. (a) 9-27-48 (b) E. G. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 2837 Messanie Street
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 23rd
 year 1948 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from March 30 to Sept 23, 1948;
 that I last saw her alive on Sept 23, 1948;
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Infarction Duration ?

Due to _____

Due to _____

Other conditions Acute MI ?
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 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 Frank H. Hardigan (M. D. or other)
 Address 620 Marcell Date signed 9/23/48

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

2
-45
-30
47070

11
17
0

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, ~~_____~~

....., Registered Apprentice No.....
working under my personal supervision.

Signed *Raymond H. Meehan*

Licensed Embalmer No. 4415 Missouri

P. O. Address St. Joseph, 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.