

FILED NOV 30 1948
Registration District No. **381**

Primary Registration District No. **45-15-**

Registrar's No. **47**

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

1. PLACE OF DEATH:

(a) County Sullivan
 (b) City or town Milan
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Simpson Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether)
 In this community 76 years (years, months or days)

3. (a) PRINT FULL NAME Thomas Jahn 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 married
 6. (b) Name of husband or wife Thelma E Moore
 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased: Feb 29 1872
 (Month) (Day) (Year)

8. AGE: Years 76 Months 8 Days 18
 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Jahn Collins
 13. Birthplace Columbus Ohio
 (City, town, or county) (State or foreign country)

{ 14. Maiden name Maey Jane Collier
 15. Birthplace Madison Ind
 (City, town, or county) (State or foreign country)

16. (a) Informant Root Collins
 (b) Address Milan - 1110

17. (a) Burial (b) Date thereof 11/20/48
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Newtown Cem.

18. (a) Signature of funeral director Dwight Schaefer
 (b) Address Milan 1110

19. (a) Nov 27 1948 (b) Mrs. H. B. Harris
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Sullivan
 (c) City or town Milan
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17
 year 1948 hour 9 minute 1 M.

21. I hereby certify that I attended the deceased from Nov. 10
 1948 to Nov. 17 1948
 that I last saw him alive on Nov. 17
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral tumor Duration 1 wk.
 Due to arteriosclerosis 2 yrs.
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations 830
 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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature E. D. Simpson (M. D. or other) 20
 Address Milan Date signed 11-20-48

RECEIVED

District Health Officer No. 10

District File Number: 1148-2021

Date Filed NOV 29 1948

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 Dwight Schoene

Licensed Embalmer No. 2667

P. O. Address Milan - Ill.

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.