

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

#70193

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

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

NR, 1799

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Iron	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Annapolis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) Cicero c. (Last) COLLINS			4. DATE OF DEATH (Month) (Day) (Year) February 10, 1949		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH July 22, 1902	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sabula, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Hartford Collins		13b. MOTHER'S MAIDEN NAME Nellie Johnson	
14. NAME OF HUSBAND OR WIFE Helen Collins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME LaVerta Dillard, 7626		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hematemesis ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. DUE TO (b) Esophageal Varices DUE TO (c) Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/8/48 to 2/10/49, 19, that I last saw the deceased alive on 2/10/49, 19, and that death occurred at 1:25 PM, from the causes and on the date stated above.					
23a. SIGNATURE Edw. G. Czubinski M.D.		(Degree or title)		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 2/11/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-12-49	
24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) Annapolis, Mo.		(State)	
DATE REC'D BY LOCAL REG. FEB 11 1949		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	

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AUG 1 1932

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.....

Student Embalmer No.

working under my personal supervision.

Signed..... *Frank J. England*

Signed.....
Student Embalmer

Licensed Embalmer No. *2645*

P. O. Address *St. Louis, 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.