

FILED SEP 16 1949

BIRTH NO.		REG. DIST. NO. <u>391</u>		PRIMARY REG. DIST. NO. <u>6153</u>		Registrar's No. <u>26</u>	
1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Stoddard</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Pike town</u>		c. LENGTH OF STAY (In this place) <u>30 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Pike town</u>		103	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>at home</u>				d. STREET ADDRESS (If rural, give location) <u>near Belle City</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Salve D.</u> b. (Middle) <u>Collins</u> c. (Last) <u>Collins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6 23 1949</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Dec 24 1968</u>	
9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Stoddard Mo</u>		12. CITIZENSHIP OF WHAT COUNTRY? <u>American</u>	
13a. FATHER'S NAME <u>Thomas Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Bessie King</u>		14. NAME OF HUSBAND OR WIFE <u>Geo Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bess Collins Belle City Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Senility</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>none</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1794X</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>none</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) <u>none</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>June 1, 1949</u> to <u>Death</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-20</u> , 19 <u>49</u> , and that death occurred at <u>4 PM.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Mr. Drayfield M.D.</u>				23b. ADDRESS <u>Anderson Mo</u>		23c. DATE SIGNED <u>9.28</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>9-1-49</u>		REGISTRAR'S SIGNATURE <u>Bessie Moore</u>		360		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

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

RECEIVED SEP 10 1949

District Health Office No. _____

District File Number 949

Date Filed _____

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 _____

Signed _____
Student Embalmer

Licensed Embalmer No. _____

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.