

FILED JUL 8 1950

STANDARD CERTIFICATE OF DEATH

21438

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5659**

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

1. PLACE OF DEATH a. COUNTY St. Louis-Mo.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. LENGTH OF STAY (In this place) 12 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St Louis 2119	
3. NAME OF DECEASED a. (First) MATTIE b. (Middle) _____ c. (Last) COLLINS		4. DATE OF DEATH (Month) (Day) (Year) June 25, 1950	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 4-16-1881
9. AGE (In years) (Month) (Day) (Year) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	
11. BIRTHPLACE (State or foreign country) Louisiana, Mo		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Samuel Collins		13b. MOTHER'S MAIDEN NAME Florida Ficklein	
14. NAME OF HUSBAND OR WIFE _____		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X	
16. SOCIAL SECURITY NO. X		17. INFORMANT'S SIGNATURE OR NAME The Sanitarian Records	
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) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Generalized Arteriosclerosis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
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) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 420.0		22. I hereby certify that I attended the deceased from Jan. 1, 1945 , to June 25, 1950 , that I last saw the deceased alive on June 25, 1950 , and that death occurred at 7:30 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE Jack R. Delwan MD		23b. ADDRESS 5400 Arsenal St.	
23c. DATE SIGNED 6/26/50		24a. BURIAL, CREMATION, REMOVAL (Specify) 6-29-50	
24b. DATE 6-29-50		24c. NAME OF CEMETERY OR CREMATORY Anatomical Bond	
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary, Inc.	
DATE REC'D BY LOCAL REG. 6-29-50		REGISTRAR'S SIGNATURE J. B. Sasser	
25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary, Inc.		ADDRESS 4104 06 Manchester	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

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.