

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17255

FILED JUN 13 1951

State File No.

BIRTH NO. _____ REG. DIST. NO. 200 PRIMARY REG. DIST. NO. 5725 Registrar's No. 47

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Macon</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Macon</u> | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hudson Township Rural</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Macon R.F.D. 0610</u> | |
| c. LENGTH OF STAY (in this place) <u>10 yrs</u> | | d. STREET ADDRESS (If rural, give location) <u>Lake View Rest Home</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Lake View Rest Home</u> | | | |

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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Amelia M. Collins</u> b. (Middle) _____ c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>May 29 1951</u> | | |
|--|--|--|--|--|--|

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|----------------------|--|-------------------------------|--|---|--|--|--|--|--|
| 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 1861</u> | | 9. AGE (In years last birthday) <u>89</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>4</u> IF UNDER 24 HRS. Hours _____ Min. _____ | |
|----------------------|--|-------------------------------|--|---|--|--|--|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work on farm</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
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|---------------------------------------|--|--|--|--|--|
| 13a. FATHER'S NAME <u>John Sailor</u> | | 13b. MOTHER'S MAIDEN NAME <u>Mary Sailor</u> | | 14. NAME OF HUSBAND OR WIFE <u>James^B Collins Leonard^M</u> | |
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| 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 <u>Mrs Cora Collins R. Hunter M.</u> ADDRESS _____ | |
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| 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, asphyxia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Natural infirmities of old age</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>few hrs.</u> | |
| | | ANTECEDENT CAUSES 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. | | | | | |

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|------------------------|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>794X</u> | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
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| 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) | |
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|--|--|--|--|----------------------------|--|
| 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? | |
|--|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from 1945, to May 29, 1951, that I last saw the deceased alive on May 28, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.

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|--|--|---------------------------|--|--------------------------------|--|
| 23a. SIGNATURE <u>Arvid Collins MD</u> (Degree or title) | | 23b. ADDRESS <u>Macon</u> | | 23c. DATE SIGNED <u>6/1/51</u> | |
|--|--|---------------------------|--|--------------------------------|--|

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|---|--|----------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>May 31-51</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Wm. Olive</u> | | 24d. LOCATION (City, town, or county) (State) <u>Near Nicklston Macon Mo.</u> | |
|---|--|----------------------------|--|---|--|---|--|

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| DATE REC'D BY LOCAL REG. <u>6/5/51</u> | | REGISTRAR'S SIGNATURE <u>Duth McNeely 195</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H.M. Woodbury Atlanta Mo</u> ADDRESS _____ | |
|--|--|---|--|--|--|

RECEIVED 6.11.51
MACON COUNTY HEALTH DEPARTMENT
County File No. 6.51.89
Date Filed 6.12.51

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.

Student
Student Embalmer

Signed HM Gooding

Licensed Embalmer No. 1750

P. O. Address Atlanta, 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.