

FILED MAY 17 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17940
4439

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

1. PLACE OF DEATH a. COUNTY		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. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1906a So 12th St		4. STREET ADDRESS (If rural, give location) 1906a So 12th St.	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) c. (Last) Collins Jr		4. DATE OF DEATH (Month) (Day) (Year) 5 11 51	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11-9-1946
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 4 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) St. Louis Mo		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME William Collins	13b. MOTHER'S MAIDEN NAME Marie Zoff	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Collins 1906a So 12th St.

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Congenital spastic paralysis</i>		INTERVAL BETWEEN ONSET AND DEATH
	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. <i>malnutrition</i>		

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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>351X</i>
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22. I hereby certify that I attended the deceased from 9-19-1950, to 5-11-1951, that I last saw the deceased alive on 5-10-1951, and that death occurred at 4 P. M., from the causes and on the date stated above.

23a. SIGNATURE <i>A. Y. Merkin M.D.</i>	(Degree or title)	23b. ADDRESS <i>3507 Polk Ave</i>	23c. DATE SIGNED <i>5-11-51</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>5-14-51</i>	24c. NAME OF CEMETERY OR CREMATORY <i>New Picker Cem</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo</i>
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DATE REC'D BY LOCAL REG. <i>MAY 11 1951</i>	REGISTRAR'S SIGNATURE <i>J. B. Lasater</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Moylell Funeral Home 1926 Allen</i>
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(Licensed Embalmer's Statement on Reverse Side)

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

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 me

working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed Robt A. Starnam
Licensed Embalmer No. 4533
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.