

FILED SEP 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31026
Registrar's No. 298

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Sedalia, Missouri</u>	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) <u>2400 S. Ingram</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Bothwell Memorial Hosp</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Flora</u>	b. (Middle) <u>Belle</u>	c. (Last) <u>Collins</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 16 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>Married</u>	8. DATE OF BIRTH <u>June 10, 1883</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>_____</u> Min. <u>_____</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	11. BIRTHPLACE (State or foreign country) <u>Benton County Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Calvin Wilson</u>	13b. MOTHER'S MAIDEN NAME <u>Virginia Forde</u>	14. NAME OF HUSBAND OR WIFE <u>Henry Thomas Collins</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. Violet Vinson, Sedalia, Mo</u>	ADDRESS <u>Sedalia, Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Cholecystitis, Jaundice.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Possible Carcinoma of the Pancreas.</u>		<u>?</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dental Caries.</u> <u>Arterio- Sclerosis- Advanced.</u>		<u>?</u>	

19a. DATE OF OPERATION <u>Refused operation.</u>	19b. MAJOR FINDINGS OF OPERATION <u>Refused operation.</u>	20. AUTOPSY? <u>Refused</u> <input type="checkbox"/>
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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>157X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <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>Over Please.</u>
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22. I hereby certify that I attended the deceased from July 27th, 1951, to Sept. 16th, 1951, that I last saw the deceased alive on Sept. 15th, 1951, and that death occurred at # 3 Ave from the causes and on the date stated above.

23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u>	(Degree or title) <u>Jno B Carlisle M.D.</u>	23b. ADDRESS <u>Sedalia, Missouri.</u>	23c. DATE SIGNED <u>9-17-51.</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept 18, 51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>9/18/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Sedalia, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0804
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From the time that this patient entered the hospital until she died she was never in condition to submit to X-Ray studies. She had a painless Jaundice. Surgery was considered when she first entered the hospital but it was refused. I cannot prove this diagnosis.

Jno. B. Carlisle, M.D,

Jno. B. Carlisle M.D
9.17.51

RECEIVED 9-25-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 9-25-51

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *P. E. Baker*

Signed.....
Student Embalmer

Licensed Embalmer No. *2419*

P. O. Address *Sedalia 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.