

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31425

State File No.

S. No. 300
v. 10-48 F

OCT 14 1952

BIRTH NO.

REG. DIST. NO. 139

PRIMARY REG. DIST. NO. 5541

Registrar's No. 68

0440

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

1. PLACE OF DEATH a. COUNTY <u>Holt</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Holt</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-South Union Township</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Oregon</u>	
c. LENGTH OF STAY (in this place) <u>7 days</u>		d. STREET ADDRESS (If rural, give location) <u>3 miles west of Craig, Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Frederick</u> b. (Middle) <u>Merlin</u> c. (Last) <u>Collins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 5, 1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>April 9, 1883</u>		9. AGE (In years last birthday) <u>69</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>On the farm</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>White Cloud - Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>William J. Collins</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Filmore</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Edgar Byron - Sparks, Kansas</u> ADDRESS	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>				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.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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) <u>4201</u>	
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 Oct 5, 1952, to Oct 5, 1952 that I last saw the deceased alive on Oct 5, 1952, and that death occurred at 1 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. Perry MD</u> (Degree or title)		23b. ADDRESS <u>Mound City, Mo</u>		23c. DATE SIGNED <u>10-6-52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial + Removal</u>		24b. DATE <u>5/10/8/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch</u>		24d. LOCATION (City, town, or county) (State) <u>near White Cloud, Kansas</u>	
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DATE REC'D BY LOCAL REG. <u>10-7-1952</u>		REGISTRAR'S SIGNATURE <u>James D. Crawford</u> 469		25. FUNERAL DIRECTOR'S SIGNATURE <u>Willow L. Schober - Craig, Mo</u> ADDRESS	
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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 _____

myself Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *Wilber L. Schooner*

Licensed Embalmer No. *3997*

P. O. Address *Craig, MD*

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.