

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31544

State File No.

3885

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1602 Registrar's No.

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Albany</u>	
c. LENGTH OF STAY (In this place) <u>4 days</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Lukes Hospt.</u>		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Mabel</u> b. (Middle) <u>Blondina</u> c. (Last) <u>Collier</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 31 52</u>		
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>Wht.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 1, 1896</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months Days Hours Mins.
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		11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	
13a. FATHER'S NAME <u>W. C. Addison</u>			13b. MOTHER'S MAIDEN NAME <u>Mary E. Dator</u>		14. NAME OF HUSBAND OR WIFE <u>Ora Collier</u>

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>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Ora Collier, Albany, Mo.</u>	
--	--	-----------------------------------	--	---	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subacute viral hemorrhagic</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused 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"/>
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) m.		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 8/27, 1952, to 8/31, 1952, that I last saw the deceased alive on 8/31, 1952, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE <u>P. L. Byers M.D.</u> (Degree or title)		23b. ADDRESS <u>4635 Woodlark, K.C. Mo</u>		23c. DATE SIGNED <u>9/2/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9/1/52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Albany MO.</u>	

DATE REC'D BY LOCAL REG. <u>9-3-52</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Stine & McClure K. C. MO.</u>	
--	--	---	--	---	--

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

