

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10653

State File No. \_\_\_\_\_

FILED MAR 23 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 635

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>	c. LENGTH OF STAY (in this place) <u>3 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>		d. STREET ADDRESS (If rural, give location) <u>7727 Water St.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Michael</u> b. (Middle) <u>A.</u> c. (Last) <u>Collings</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 10, 1954</u>		
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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>February 15, 1952</u>	9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>---NONE---</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Bruce Collings</u>	13b. MOTHER'S MAIDEN NAME <u>Helen Knichel</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) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Bruce Collings 7727 Water St.</u>	
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Brain tumor</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Shock of lengthy and difficult surgery</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>
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19a. DATE OF OPERATION <u>3/9/54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Brain Tumor</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-8 <sup>1954</sup> to 3-10 <sup>1954</sup>, that I last saw the deceased alive on 3/10 <sup>1954</sup>, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>R. Bauer M.D.</u> (Degree or title)	23b. ADDRESS <u>6420 Clayton Rd</u>	23c. DATE SIGNED <u>3/11/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>March 13, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>3700 Mt. Olive Road, Lemay, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>3/2/54</u>	REGISTRAR'S SIGNATURE <u>Hedrick R. Sporken</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C. Hoffmeister U. &amp; L. Co. 7814 S. Broadway</u>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Lin C Hoffmann*

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

**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.