

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

**35239**

No. 300  
10.48

**FILED NOV 1 - 1954**

State File No. ....

BIRTH NO. 81010-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9529

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY   |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <u>St. Louis</u> |  | c. LENGTH OF STAY (in this place)<br><u>13 hrs</u> | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <u>St. Louis</u>                                    |  | d. STREET ADDRESS (If rural, give location)<br><u>20 2527 N. Market</u> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hosp.</u>                              |  |  | 2209   |  |   |

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| <b>3. NAME OF DECEASED</b><br>(Type or Print)<br>a. (First) <u>Collins</u><br>b. (Middle)<br>c. (Last) |   |   | <b>4. DATE OF DEATH</b><br>(Month) (Day) (Year)<br><u>10 8 54</u> |   |  |
| <b>5. SEX</b><br><u>Male</u>   | <b>6. COLOR OR RACE</b><br><u>Negro</u> | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify)<br><input checked="" type="radio"/> | <b>8. DATE OF BIRTH</b><br><u>10-8-54</u>                         |   | <b>9. AGE</b> (In years last birthday) <u>13</u> <b>IF UNDER 1 YEAR</b> Months <u>45</u> <b>IF UNDER 6 HRS.</b> Hours <u>13</u> <b>IF UNDER 15 MIN.</b> Min. <u>45</u> |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)     |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Missouri</u> |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b>  |   | <u>C</u>  |   |   |  |

|                           |  |  |  |                                    |  |
|---------------------------|--|--|--|------------------------------------|--|
| <b>13a. FATHER'S NAME</b> |  | <b>13b. MOTHER'S MAIDEN NAME</b><br><u>Rosie Lee Collins</u> |  | <b>14. NAME OF HUSBAND OR WIFE</b> |  |
|---------------------------|--|--|--|------------------------------------|--|

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)  |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT'S SIGNATURE OR NAME</b><br><u>Arthur M. Sheward</u> , R.R.L. 2601 N. Whittier |  |
| <b>18. CAUSE OF DEATH</b><br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | <b>MEDICAL CERTIFICATION</b><br><b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Prematurity</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |  |  |  |
| <b>19a. DATE OF OPERATION</b>  |  | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |  | <b>20. AUTOPSY?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| <b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)               |  | <b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | <b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> |  |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) |  | <b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | <b>21f. HOW DID INJURY OCCUR?</b><br><u>776X</u>       |  |

**22. I hereby certify that I attended the deceased from** 10-8, 1954, to 10-8, 1954, that I last saw the deceased alive on 10-8, 1954, and that death occurred at 3:30p m., from the causes and on the date stated above.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <b>23a. SIGNATURE</b><br><u>William H. Sinkler</u> |  | <b>23b. ADDRESS</b><br><u>M.D. 2601 N. Whittier Street</u> |  | <b>23c. DATE SIGNED</b><br><u>10-14-54</u> |  |
|--|--|--|--|--|--|

|  |  |                                     |  |   |  |
|--|--|-------------------------------------|--|---|--|
| <b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) |  | <b>24b. DATE</b><br><u>10-30-54</u> |  | <b>24c. NAME OF CEMETERY OR CREMATORY</b><br><u>Anatomical Board</u>          |  |
|  |  |                                     |  | <b>24d. LOCATION</b> (City, town, or county) (State)<br><u>St. Louis, Mo.</u> |  |

|  |  |   |  |
|--|--|---|--|
| <b>DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE</b><br><u>OCT 20 1954</u><br><u>J. Carl Smith</u> |  | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Rowland-Aker Mortuary Service</u><br>4104 Manchester Ave.<br>St. Louis, Mo. |  |
|--|--|---|--|

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

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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 \_\_\_\_\_

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.