

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38633
9756

State File No.

Registrar's No.

FILED NOV 22 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION H. O. H. Homer Phillips Hosp/		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Allen b. (Middle) Nathen c. (Last) Collier		4. DATE OF DEATH (Month) (Day) (Year) 10 23 54	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2-22-1887
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Shaw, Mississippi
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Charles Collier	
13b. MOTHER'S MAIDEN NAME Barbara Collier		14. NAME OF HUSBAND OR WIFE Barbara Collier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Barbara Collier		ADDRESS 220 S. Leffingwell	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) CONGESTIVE HEART FAILURE			
18. CAUSE OF DEATH (Continued) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. 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 checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4341		22. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:47 m., from the causes and on the date stated above.	
23a. SIGNATURE Joseph M. Dickson		23b. ADDRESS 1300 Clair	
23c. DATE SIGNED 10/27/54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 10-29-54		24c. NAME OF CEMETERY OR CREMATORY Father Dickson	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Russell Und., Co.	
DATE REC'D BY LOCAL REG. OCT 27 1954		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	
ADDRESS 2732 Pine Blv		5.0 (Licensed Embalmer's Statement on Reverse Side)	

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.....
Signature of Student Embalmer

Signed *James A. Carter*.....

Licensed Embalmer No. *468*.....

P. O. Address *P. O. Box 13*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.