

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39441

State File No.

FILED NOV 29 1955

BIRTH NO. _____ REG. DIST. NO. 352 PRIMARY REG. DIST. NO. 4517 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>TANEY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>TANEY</u>	
b. CITY OR TOWN <u>BRANSON</u>	c. LENGTH OF STAY (in this place) <u>1WK</u>	c. CITY OR TOWN <u>KISSEE MILLS</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SKAGGS Hosp.</u>		e. STREET ADDRESS (If rural, give location) <u>rural Kissee Mills</u>	

3. NAME OF DECEASED (Type or Print) <u>ALBERT TEAN COLLINS</u>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>NOV 10 1955</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>widowed</u>	8. DATE OF BIRTH <u>Sept 15, 1881</u>	9. AGE (in years last birthday) <u>74</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Jim Collins</u>	13b. MOTHER'S MAIDEN NAME <u>ELISA Shaw</u>	14. NAME OF HUSBAND OR WIFE <u>deceased</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 <u>Dorsey Collins</u> ADDRESS <u>Branson, Mo</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ruptured Cerebral Artery</u> DUE TO (c) <u>General Atherosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>			

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)
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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 Nov 3rd, 1955, to Nov 10th, 1955, that I last saw the deceased alive on Nov 3rd, 1955, and that death occurred at 9⁴⁵ m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr</u>	23b. ADDRESS <u>Forsyth, Mo</u>	23c. DATE SIGNED <u>11/15/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-12-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cobbe Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Redeek Creek, Mo</u>
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DATE REC'D BY LOCAL REG. <u>11/25/55</u>	REGISTRAR'S SIGNATURE <u>Dorsey Collins</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Forsyth</u> ADDRESS <u>Funeral Home Forsyth</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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48

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... *Walter S. Cobb*

Licensed Embalmer No... *97*

P. O. Address... *Forrest*

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.