

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 6 1956

State File No. **20450**
F
2437

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY Jackson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City c. LENGTH OF STAY (in this place) 70 yrs.
c. CITY OR TOWN Kansas City d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hospital STREET ADDRESS (If rural, give location) 83 5630 Brookside 38280

3. NAME OF DECEASED a. (First) MARY b. (Middle) C. c. (Last) COLLINS 4. DATE OF DEATH (Month) (Day) (Year) June 3, 1956

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH April 8, 1862 9. AGE (In years last birthday) 94 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) Receptionist 10b. KIND OF BUSINESS OR INDUSTRY Long Bldg. 11. BIRTHPLACE (City and State or Foreign Country) Upper Sandusky, Ohio 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Clinger 13b. MOTHER'S MAIDEN NAME unknown 14. NAME OF HUSBAND OR WIFE John W. Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Henry S. Wiese 1613 Summit

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal heart disease
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) arterio sclerosis
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured hip 5-27-56

INTERVAL BETWEEN ONSET AND DEATH 1 month
20 yrs.
4500F

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1926, 19 , to 6-3- 1956, that I last saw the deceased alive on 6-2, 1956, and that death occurred at 11a m., from the causes and on the date stated above.

23a. SIGNATURE E. W. Slusher (Degree or title) 23b. ADDRESS 900 Reatta Bldg, KC Mo 23c. DATE SIGNED 6-4-56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE June 5, 1956 24c. NAME OF CEMETERY OR CREMATORY Mt. St. Mary's Cem. 24d. LOCATION (City, town, or county) (State) Kansas City, Mo.

DATE REC'D BY LOCAL REG. 6-4-56 REGISTRAR'S SIGNATURE Meva Minshall 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar Kansas City, Mo.

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

Dr. Shuckler + D. Wash
Re ad to B. G. by
112-2966

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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
Signature of Student Embalmer

Signed *Juan E. Miller*

Licensed Embalmer No. *498*

P. O. Address *N. C., N.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.