

FILED DEC 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44286
STATE FILE NUMBER
Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5631

1. PLACE OF DEATH a. COUNTY JACKSON			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE KANSAS b. COUNTY Wyandotte		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL		Length of stay in lb 5 weeks	d. STREET ADDRESS 1411 MINNESOTA		(If outside, give location) 8111 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RILEY Middle C. Last COLLINS			4. DATE OF DEATH Month November Day 27 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1899	9. AGE (In years at birthday) 58 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Lincoln, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Albert Collins		13b. MOTHER'S MAIDEN NAME Rose O'Neal		14. NAME OF HUSBAND OR WIFE Laura	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address VA Hospital Official Records, K. C. Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anasarca					INTERVAL BETWEEN ONSET AND DEATH 58¹⁰
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) Cirrhosis of the liver					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from October 21, 1957 to November 27, 1957 . Death occurred at 9:35 AM on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE A. J. WILLIAMS (Degree or title) D			22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 11/27/57
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 11-28-57	23c. NAME OF CEMETERY OR CREMATORY BEATY CEMETERY		23d. LOCATION (City, town, or county) (State) LINCOLN ARKANSAS
24. FUNERAL DIRECTOR D. W. Newcomer's Sons K.C. Mo.		25. DATE RECD. BY LOCAL REG. 11-28-57		26. REGISTRAR'S SIGNATURE Reva Marshall	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



DEC 18 1952

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

X by me, or by Student Embalmer No.

working under my personal supervision.

Student

Signature of Student Embalmer

Signed *Chester K. Brown*

Licensed Embalmer No. *4931*
P. O. Address *KC Mo*

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.