

Dept. Health,
uc., & Welfare
J. S. Public
Health Service

SL-13755
XC-1 207 468
FILED FEB 4 1958

STANDARD CERTIFICATE OF DEATH

47513
STATE HEALTH NUMBER
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12640

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ROBERTSON, 4000 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND		Length of stay in lb 7 DAYS	d. STREET ADDRESS (If outside, give location) 172 FAIRVIEW

3. NAME OF DECEASED (Type or print) First Middle Last JOHN P. COLLINS			4. DATE OF DEATH Month Day Year 12/30/57		
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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 8/16/94	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT	10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME PATRICK COLLINS	13b. MOTHER'S MAIDEN NAME MARY DOHONEY	14. NAME OF HUSBAND OR WIFE MYRTLE P. COLLINS
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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) YES WW-I	16. SOCIAL SECURITY NO. 497-01-9272	17. INFORMANT Address VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE BRONCHO-PNEUMONIA . INTERVAL BETWEEN ONSET AND DEATH 5 Days CARCINOMA LEFT LUNG 8 Months Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - - DUE TO (c) - -		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"/>
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20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 1634
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT 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
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21. I attended the deceased from 12/23/57 to 12/30/57 and last saw him alive on 12/30/57 Death occurred at 9:20 AM m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) H. W. Schaefer M.D.	22b. ADDRESS VAH, ST. LOUIS, MISSOURI	22c. DATE SIGNED 12/30/57
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23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE 12/30/57	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo.
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24. FUNERAL DIRECTOR Collier's Mortuary St. Ann Mo.	25. DATE RECD. BY LOCAL REG. DEC 31 57	26. REGISTRAR'S SIGNATURE Carl Smith MD
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(Licensed Embalmer's Statement on Reverse Side)

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

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

Sheldon Collier

Licensed Embalmer No. *3382*

P. O. Address *St. Ann*

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.