

FILED MAY 9 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-014121

STATE FILE NUMBER

2050

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2050

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 0170 a. STATE <b>Missouri</b> b. COUNTY <b>CARROLL</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Bogard</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>V.A. Hospital</b>		Length of stay in lb <b>2 yrs &amp; 2 mos</b>	d. STREET ADDRESS (If outside, give location) <b>307 E. 4th,</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jimmie</b> Middle <b>Collins</b> Last <b>Collins</b>			4. DATE OF DEATH Month <b>4th</b> Day <b>21st</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-10-92</b>	9. AGE (In years last birthday) <b>66 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tonsorial</b>	11. BIRTHPLACE (City and state or country) <b>Columbia, Ky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Samuel Collins</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotte Elison</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>495099575</b>	17. INFORMANT <b>V.A. Hospital Records, K.C., Mo.</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrythmia</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Diffuse collagen disease of undetermined origin</b>					<b>1912</b>
DUE TO (c) <b>Bronchopneumonia</b>					
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 type="checkbox"/> NO <input checked="" 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 <b>VA</b> Month, Day, Year a.m. <b>AT WORK</b> p.m. <input type="checkbox"/>					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <b>VA</b> 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
21. attended the deceased from <b>February 20, 1956 to April 21, 1958</b> and to the best of my knowledge, from the causes stated. Death occurred at <b>9:10p</b> m on the date stated above;					
22a. SIGNATURE <i>[Signature]</i>		(Degree or title) <b>MD</b>	22b. ADDRESS <b>V.A. Hospital, K.C., Mo</b>		22c. DATE SIGNED <b>4-21-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>	<b>April 25-58</b>	<b>MT Zion Cemetery</b>		<b>Bogard Mo.</b>	
24. FUNERAL DIRECTOR <b>Stine &amp; McClure Und. Co., K. C., Mo.</b>		ADDRESS	25. DATE RECD. BY LOCAL REG. <b>4-22-58</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

W. W. Woodward

All diseases in Part I must be causally related.



**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 *Clara D. Triplett* .....

Licensed Embalmer No. *4817* .....

P. O. Address *Kansas City, 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.