

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033174

STATE FILE NUMBER

FILED OCT 15 1958

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 218

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Prairie</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Buckner 7000</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jackson County Hosp. 6 yrs</u>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>Rt. # 1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Collings</u> Last <u>Collings</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1978</u>	9. AGE (In years last birthday) <u>80</u>	10. FUNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>South of Independence Mo USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>William Collings</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Buckler</u>		14. NAME OF HUSBAND OR WIFE <u>Mertie F Collings</u>			
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>535045-7185A</u>		17. INFORMANT <u>Mertie F Collings</u> Address <u>Indep.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> <u>Gen. Arterio-Sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4200</u>	
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.) <u>0</u>					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <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 <u>Buckner Mo</u>		COUNTY		STATE	
21. I attended the deceased from <u>10-3-58</u> to <u>10-9-58</u> and last saw <sup>her</sup> him alive on <u>10-9-58</u> Death occurred <u>12:00</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Philp Super MD</u> (Degree or title)				22b. ADDRESS <u>Lee's Summit Mo</u>		22c. DATE SIGNED <u>10-9-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Oct 11-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Buckner Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Buckner Mo</u>	
24. FUNERAL DIRECTOR <u>Hazel H Reppert</u>		ADDRESS <u>Buckner Mo</u>		25. DATE RECD. BY LOCAL REG. <u>10-10-1958</u>		26. REGISTRAR'S SIGNATURE <u>N. B. Langford</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

856: 18 100  
OCT 31 1958

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 *Charles E. Mayfield*  
.....  
Licensed Embalmer No. *4638*

P. O. Address *Blue Springs*

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.