

Health, Welfare & Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014821

STATE FILE NUMBER

23614

FILED MAY 8 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN FERGUSON <i>4119</i>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION FAITH HOSPITAL		d. STREET ADDRESS (If outside, give location) 421 RUGGLES PL.	
3. NAME OF DECEASED (Type or print) First MIDDLE Last DOROTHY L. COLLINS		4. DATE OF DEATH Month Day Year APRIL 10, 1959	
5. SEX FEMALE	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 FEB. 14, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) CARUTHERSVILLE, MO.
13a. FATHER'S NAME EDWARD WILBANKS		13b. MOTHER'S MAIDEN NAME ETHEL STIRES	14. NAME OF HUSBAND OR WIFE JAMES COLLINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address JAMES COLLINS 421 RUGGLES PL. FERGUSON
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism acute</i> DUE TO (b) <i>Postoperative following</i> DUE TO (c) <i>Hysterectomy + Rt Tubo-ovary on 4/14/59</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <i>Intractable uterine bleeding - Rt. Tubo-ovary exc.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 to 4 hours</i>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>216X</i>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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. I attended the deceased from <i>4/11/59</i> to <i>4/10/59</i> and last saw her alive on <i>4/10/59</i> Death occurred at <i>9 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>St. Carroll M.D.</i>	
22b. ADDRESS <i>1901 Madison St.</i>		22c. DATE SIGNED <i>4/10/59</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE APRIL 14, 1959	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
24. FUNERAL DIRECTOR ADDRESS STROOT CARROLL 4600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. APR 14 '59	26. REGISTRAR'S SIGNATURE <i>Head Smith, M.D.</i> <i>M. J. B.</i>

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 *M W Ruetter*

Licensed Embalmer No. *4865*
P. O. Address *St Louis 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.