

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019051  
STATE FILE NUMBER  
2 4850  
Registrar No.

FILED JUN 4 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

300  
-57

93  
0

1. PLACE OF DEATH a. COUNTY <b>St. Louis Missouri</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR D. O. A. <b>Homer G Phi</b>		d. STREET ADDRESS (If outside, give location) <b>2812 N. Newstead</b>	
Length of stay in 1b _____		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle _____ Last <b>Collier Jr</b>			4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1959</b>			
--	--	--	---	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>29 July 1927</b>	9. AGE (In years last birthday) <b>31</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-----------------------------	---	--------------------------------------	---	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <b>Labor</b>	11. BIRTHPLACE (City and state or country) <b>St Louis Missouri</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
---	--	---	--

13a. FATHER'S NAME <b>Edward Collier</b>	13b. MOTHER'S MAIDEN NAME <b>Connie Collier</b>	14. NAME OF HUSBAND OR WIFE <b>Mrs Mamie Collier</b>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>490-22993</b>	17. INFORMANT <b>Mrs Mamie Collier</b> Address <b>2812 N. Newstead Ave</b>
---	--	--

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>Massive Intra Thoracic Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) <b>Penetrating gunshot wound left chest severing the left subclavian artery.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>suffered when shot with 300 gr bullet in left chest</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (E.g., nature of injury, in PART I or PART II of item 18) <b>Shot by Porter Lee Ramey at 15088 1/2 Easton Ave. about 4:55 pm. May 17th 1959. 981x</b>
--	---

20c. TIME OF INJURY <b>4:55 p.m. 5/17/59</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20e. CITY, TOWN OR LOCATION <b>St Louis Mo</b>	COUNTY _____ STATE _____
--	--	--	--------------------------

21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <b>Joseph M. Smith, M.D.</b>	22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>5/19/59</b>
---	--------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Reburied</b>	23b. DATE <b>5/21/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) <b>St Louis County Missouri</b>
---	--------------------------	---	---

24. FUNERAL DIRECTOR <b>Herman J. Smith</b> ADDRESS <b>4247 W. Labadie Ave</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 19 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

MISSOURI DEPARTMENT OF HEALTH

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*  
P. O. Address *4500 New B*

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.