

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026304

FILED VS JUL 30 1959

STATE FILE NUMBER

Registration District No. 574 Primary Registration District No. 4459 Registrar's No. 37

1. PLACE OF DEATH a. COUNTY <b>ST. CLAIR</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>ST. CLAIR</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>OSCEOLA</b>		Length of stay in 1b	c. CITY OR TOWN <b>OSCEOLA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>OSCEOLA</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>OSCEOLA</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WILLIAM</b> Last <b>COLLINS</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>16</b> Year <b>1959</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"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6-5-24</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OSCEOLA, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13a. FATHER'S NAME <b>JAMES COLLINS</b>		13b. MOTHER'S MAIDEN NAME <b>FANNY RACER</b>		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>UREMIA</b>			<b>2 WEEKS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>RECURRENT NEPHRITIS - CYSTITIS</b>		<b>10 YRS</b>
	DUE TO (c) <b>PROSTATIC HYPERTROPHY</b>		<b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 15.)			
20c. TIME OF INJURY Hour Month, Day, Year 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	COUNTY	STATE	
21. I attended the deceased from <b>8-1-55</b> to <b>7-16-59</b> and last saw <sup>her</sup> him alive on <b>7-16-59</b> Death occurred at <b>2:10</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>H. L. Shipman D.O.</b> (Degree or title)		22b. ADDRESS <b>Osceola, Mo.</b>		22c. DATE SIGNED <b>7-17-59</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>	23b. DATE <b>7-19-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Heath &amp; Yeater Osceola, Mo</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Goodrich Home - Osceola Mo</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-18-1959</b>	26. REGISTRAR'S SIGNATURE <b>Paul D. Seewer</b>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola

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.