

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-029406**

FILED VS AUG 26 1959

Registration District No. 46 Primary Registration District No. 3026 Registrar's No. 362

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>					
b. CITY (if outside corporate limits, give TOWNSHIP only) <b>Independence</b>		Length of stay in 1b		c. CITY OR TOWN <b>Independence</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>18807 Independence Ave.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>18807 Independence Ave</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>J</b> Last <b>COLLINS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1959</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</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>12-7-1880</b>		9. AGE (last birthday) <b>78</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (City and state or country) <b>Carroll Co., Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>T. J. Pyle</b>			13b. MOTHER'S MAIDEN NAME <b>Ollie Allen</b>			14. NAME OF HUSBAND OR WIFE <b>Garner Collins</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Garner Collins 18807 Indep. 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>RIGHT VENTRICULAR HEART FAILURE</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>CEREBRAL VASCULAR ACCIDENT</b>				ONE MONTH		
			DUE TO (c) <b>ARTERIO SCLEROSIS</b>				TWO YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>PARKINSON'S DISEASE</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____ a.m. _____ p.m. Month, Day, Year _____									
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>12 AUG 59</b> , to <b>15 AUG 59</b> and last saw her alive on <b>12 AUG 59</b> Death occurred at <b>12:45 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Robert F. Murphy D.O.</b>				22b. ADDRESS <b>3303 E. 31st St.</b>			22c. DATE SIGNED <b>15 AUG 59</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-17-59</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mound Grove</b>		23d. LOCATION (City, town, or county) <b>Independence, Missouri</b>		(Sign)	
24. FUNERAL DIRECTOR <b>Roland R. Speaks Independence, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>8-17-59</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Rollie Fessel

Licensed Embalmer No. 4690

P. O. Address Indep. 1

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.