

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036021

FILED VS NOV 9 1959

STATE FILE NUMBER

Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 146

1. PLACE OF DEATH a. COUNTY <u>Navarro</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Navarro</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>West Plains</u>		c. CITY OR TOWN <u>Willow Springs</u>	
Length of stay in 1b <u>17 1/2</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>Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>Rte 1</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Anthony F.</u> Middle <u>Collins</u> Last <u></u>			4. DATE OF DEATH Month <u>10</u> -Day <u>14</u> -Year <u>1959</u>	
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18-78</u>	9. AGE (last birthday) <u>81</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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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></u>	11. BIRTHPLACE (City and state or country) <u>Silsbee Springs, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>C. Collins</u>	13b. MOTHER'S MAIDEN NAME <u>Dacia Barton</u>	14. NAME OF HUSBAND OR WIFE <u></u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>Yes</u>	17. INFORMANT <u>Lucy Hamilton, West Plains, Mo</u>	Address <u></u>
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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 <u>17 days</u>
IMMEDIATE CAUSE (a) <u>Post-operative infection</u>	DUE TO (b) <u>Prostectomy</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>Urinary obstruction</u>	DUE TO (c) <u>Urinary obstruction</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile Dementia</u>		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 18.) <u></u>
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20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>	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.) <u></u>	20f. CITY, TOWN, OR LOCATION <u></u> COUNTY <u></u> STATE <u></u>
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21. I attended the deceased from <u>9-26-59</u> to <u></u> and last saw her/him alive on <u>10-14-59</u>	
Death occurred at <u>11:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <u>[Signature]</u> (Degree or title) <u></u>	22b. ADDRESS <u>West Plains, Mo</u>	22c. DATE SIGNED <u>12/14/59</u>
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23a. BURIAL, CREMATION, OR REINTERMENT (Specify) <u></u>	23b. DATE <u>10/17-59</u>	23c. NAME OF CEMETERY, OR CREMATORY <u>Carroll</u>	23d. LOCATION (City, town, or county) (State) <u>Willow Springs, Mo</u>
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24. FUNERAL DIRECTOR <u>Kabern, West Plains, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-4-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>
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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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

J. J. Roberts

Licensed Embalmer No. *3437*

P. O. Address *West Ha*

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.