

## RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036503

FILED VS NOV 4 1959

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 468

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>JA.</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Independence</b>		Length of stay in 1b <b>life</b>		c. CITY OR TOWN <b>Independence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Kirby Rest Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>118 E Walnut St.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH Unk COLLINS</b>				4. DATE OF DEATH Month Day Year <b>Oct 22 59</b>				
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30 1861 98</b>		
9. AGE (last birthday) <b>98</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>Teacher (retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>			11. BIRTHPLACE (City and state or country) <b>Independence, Mo</b>		
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			13a. FATHER'S NAME <b>Andrew Collins</b>		13b. MOTHER'S MAIDEN NAME <b>Isabel Sterling</b>		14. NAME OF HUSBAND OR WIFE <b>None</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 Address <b>Mrs Ruth Keck Indep. Mo.</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>acute cardiac arrest</b> DUE TO (b) <b>Recurrent Myocardial Decompensation (?) years</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension - Arteriosclerosis - Senility</b>						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 - 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.)				
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>11/8/59</b> to <b>10/22/59</b> and last saw her alive on <b>10/22/59</b> Death occurred at <b>12:30 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>M. L. Whitton D.O.</b>				22b. ADDRESS <b>Independence, Mo</b>		22c. DATE SIGNED <b>10/23/59</b>		
23a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		23b. DATE <b>Oct. 24, 1959</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		23d. LOCATION (City, town, or county) <b>Indep, Mo.</b>		
24. FUNERAL DIRECTOR <b>OTT &amp; MITCHELL</b>			ADDRESS <b>INDEP., MO</b>		25. DATE RECD. BY LOCAL REG. <b>10-24-59</b>		26. REGISTRAR'S SIGNATURE <b>James Strain</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



Licensed Embalmer No. 3156

P. O. Address Independence

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.