

JR. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-022720

FILED VS JUL 5 1960

Registration District No. 100 Primary Registration District No. \_\_\_\_\_ Registrar's No. 51 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>DENT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>DENT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Current</u>		Length of stay in 1b <u>87 yrs</u>	c. CITY OR TOWN <u>Licking</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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>miles E of Licking Mo</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Timothy (Tim) Collins</u>			4. DATE OF DEATH Month Day Year <u>June 23, 1960</u>
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>9-25-1867-92+</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bowling Green Ky</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>92+</u>
11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Tim Collins</u>		13b. MOTHER'S MAIDEN NAME <u>Katy Mernan</u>	14. NAME OF HUSBAND OR WIFE _____
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Lawrence Collins Licking Mo</u> Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>
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 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 <u>10-15-59</u> to <u>6-17-60</u> and last saw <sup>her</sup> him <u>live</u> on <u>6-17-60</u> Death occurred at <u>3:00</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>JH HUNT</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>SALEM, MO</u>	22c. DATE SIGNED <u>6/26/60</u>
23a. BURIAL, CREMATION, OR MOVAC (Specify) <u>Burial</u>	23b. DATE <u>6-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Licking Cem.</u>	23d. LOCATION (City, town, or county) <u>Licking MO</u> (State) <u>MO</u>
24. FUNERAL DIRECTOR <u>Smith-Ferguson Licking Mo</u> ADDRESS _____		25. DATE RECD. BY LOCAL REG. <u>6/30/60</u>	26. REGISTRAR'S SIGNATURE <u>M.M. Nash, M.D. au</u>

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

*Erbert Ferguson*

Licensed Embalmer No. 3948

P. O. Address Richmond

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.