

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034688

FILED VS OCT 1 0 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4850 STATE FILE NUMBER

IDED

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>                         |  | Length of stay in 1b<br><b>40 YEARS</b>  | c. CITY OR TOWN <b>KANSAS CITY</b>                                      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>TRINITY LUTHERAN HOSPITAL</b> |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | d. STREET ADDRESS (If outside, give location)<br><b>2611 AMIE COURT</b> |
|   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |

|   |                                  |   |   |   |   |  |  |
|---|----------------------------------|---|---|---|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elmo</b> Middle <b>M.</b> Last <b>Collins</b>                                       |                                  |   | 4. DATE OF DEATH<br>Month <b>SEPTEMBER</b> Day <b>23</b> Year <b>1960</b> |   |   |  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JAN. 3, 1903</b>                                   | 9. AGE (last birthday)<br><b>57</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HR                               |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OPERATOR - MERCHANT</b>           |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HARDWARE STORE</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>CAMERON, TEXAS</b>                             |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b> |  |
| 13a. FATHER'S NAME<br><b>JESS CASS</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>MINNIE J. MESERVE</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>MRS. GARNETT M. COLLINS</b>                                   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES WORLD WAR II</b> |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>   |   | 17. INFORMANT<br><b>MRS. GARNETT M. COLLINS</b> Address <b>2611 AMIE COURT KANSAS CITY, MO.</b> |   |  |  |

|   |   |  |
|---|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>  |   | <b>4 days</b>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <b>Cerebral Hypertension</b>     | <b>5 years</b>   |
|   | DUE TO (c) <b>Hypertension, Generalized</b> | <b>5 years.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Obesity</b> |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

|   |   |  |
|---|---|--|
| 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.<br>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 9-20-60 to 9-23-60 and last saw <sup>her</sup>him alive on 9-23-60  
Death occurred at 6:45 P. on the date stated above, and to the best of my knowledge, from the causes stated.

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|--|--|---|---|
| 22. SIGNATURE (Degree or title)<br><b>Otto W. Theel M.D.</b>   |  | 22b. ADDRESS<br><b>4301 Main St. KCMo</b>           | 22c. DATE SIGNED<br><b>9-29-60</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE<br><b>SEPT. 26, 1960</b>             | 23c. NAME OF CEMETERY<br><b>MT. MORIAH CEMETERY</b> | 23d. LOCATION (City, town, or county) (State)<br><b>KANSAS CITY, MISSOURI</b> |
| 24. FUNERAL DIRECTOR<br><b>D. W. NEWCOMER'S SONS</b> ADDRESS<br><b>1331 BRUSH CREEK KANSAS CITY, MO.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>9-26-60</b> | 26. REGISTRAR'S SIGNATURE<br><b>H-L-Dwyer</b>       |   |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF  
Otto W. Theel

**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 Raymond M. Hardy

Licensed Embalmer No. 4913

P. O. Address Indigo, Md.

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.