ISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7625 — 61-030638 STATE FILE NUMBER

AMENDED

DATE AMENDED

FILED AUG 23 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO — Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST.LOUIS CITY HOSP. #1. — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY
c. CITY OR TOWN: ST.LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1715 N. 23rd. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JOHNNY Middle DALE Last COLLIER
4. DATE OF DEATH: Month AUG. Day 8, Year 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8/8/61
9. AGE (last birthday) — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours 4, Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): ST.LOUIS,MO
12. CITIZEN OF WHAT COUNTRY: U.S.A
13a. FATHER'S NAME: FLOYD WILLARD COLLIER
13b. MOTHER'S MAIDEN NAME: DOROTHY MARIE MOORE
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: ST.LOUIS CITY HOSP, #1. Address.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Immaturity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 776 x
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 8/8/61, to 8/8/61 and last saw her/him alive on 8/8/61
Death occurred at 10:15 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wilma Classman MD
22b. ADDRESS: 1515 LAFAYETTE AVE
22c. DATE SIGNED: 8/ 8/61.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE: 8-31-61
23c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
23d. LOCATION (City, town, or county) (State): St. Louis, Mo.

24. FUNERAL DIRECTOR: Rowland Mortuary Svc. ADDRESS: 4104-06 Manchester
25. DATE RECD. BY LOCAL REG.: AUG 17 1961
26. REGISTRAR'S SIGNATURE: Earl Smith M.D.

ITEM NO. | SHOULD READ | INSTEAD OF | DOCUMENT | 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_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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.