

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025425

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1669

FILED JUL 2 1962

VS 300 Rev. 4/59

14000
20505

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MANCHESTER Length of stay in lb 1MO. 5DAYS c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PINE CREST NURSING HOME Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY JEFFERSON c. CITY OR TOWN DE SOTO Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) 811 KENNETT Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLA COLLIER			4. DATE OF DEATH Month Day Year MAY 30 1962
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1874
9. AGE (last birthday) 88		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) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) MISSOURI
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME UNK.	
14. MOTHER'S MAIDEN NAME UNK.		15. NAME OF HUSBAND OR WIFE JOSEPH COLLIER	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE	18. INFORMANT GERALD J. MAHN DE SOTO, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Arterio-sclerotic Cardio-vascular Disease</i> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>10 Days</i>
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 checked="" 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"/> <i>NO</i>	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 <i>4-25-62 5-30-62</i>		COUNTY STATE
21. I attended the deceased from <i>4-25-62</i> to <i>5-30-62</i> and last saw her/him alive on <i>5-21-62</i> . Death occurred at <i>2:30 p.</i> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Allen M. Nearney M.D.</i> (Degree or title)		22b. ADDRESS <i>4308 E. Peter</i>	22c. DATE SIGNED <i>5-31-62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE <i>6-3-62</i>	23c. NAME OF CEMETERY OR CREMATORY CITY	23d. LOCATION (City, town, or county) (State) BE SOTO MO.
24. FUNERAL DIRECTOR MAHN FUNERAL HOME DE SOTO MO.		25. DATE RECD. BY LOCAL REG. <i>6-3-1962</i>	26. REGISTRAR'S SIGNATURE <i>John C. Murphy M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

MS JUL 2 1962

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 Gerald J Mahr

Licensed Embalmer No. 4975

P. O. Address De Soto, Mo

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.