

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-025426

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1945

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 9 1962

VS 300
Rev. 4/59

1 4000

2 8120

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY MADISON	
b. CITY (If outside corporate limits, give TOWNSHIP only) JEFFERSON BARRACKS, MO.		c. CITY OR TOWN GRANITE CITY	
Length of stay in 1b 62 DAYS		Inside Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS (If outside, give location) 2241 A WASHINGTON	
3. NAME OF DECEASED (Type or print) First HENRY Middle (NMI) Last COLLIER		4. DATE OF DEATH Month 7 Day 1 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-7-92
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO ASSEMBLER		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	11. BIRTHPLACE (City and state or country) OLMSTEAD, KENTUCKY
13a. FATHER'S NAME THOMAS COLLIER		13b. MOTHER'S MAIDEN NAME ANNA MILLER	14. NAME OF HUSBAND OR WIFE MARGUERITE COLLIER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		17. INFORMANT Address MARGUERITE COLLIER 2241A WASHINGTON / GRANITE CITY, ILL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PULMONARY EMBOLI			Immediate
DUE TO (b) THROMBOPHLEBITIS, RIGHT LEG			24 Hours
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) OLDER PULMONARY EMBOLI WITH INFARCTION - 3 DAYS			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
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition given in PART I (a) CEREBRAL VASCULAR ACCIDENT LEFT HEMISPHERE - 2 MOS			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	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. VA attended the deceased from 5-1-62 to 7-1-62		and last saw him alive on _____	
Death occurred at 1:10 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John J. Mueller</i> JOHN J. MUELLER, M.D.		22b. ADDRESS VA HOSP. JEFF. BRKS, MO.	22c. DATE SIGNED 7-1-62
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 7-5-1962	23c. NAME OF CEMETERY OR CREMATORY NATIONAL JEFFERSON BARRACKS	23d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS, MO.
24. FUNERAL DIRECTOR ADDRESS MERCER FUNERAL HOME GRANITE CITY ILL.		25. DATE RECD. BY LOCAL REG. 7-2-62	26. REGISTRAR'S SIGNATURE <i>John B. Murphy M.D.</i>

USE BLACK INK OR TYPEWRITER RIBBON

AUG 9 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 Shinston C. Williams

Licensed Embalmer No. 5016

P. O. Address Granite City, Ill.

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.