

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009739

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 290

DO NOT WRITE ON THIS STUB

AMENDED

<b>FILED FEB 19 1963</b>	
1. PLACE OF DEATH a. COUNTY <b>Saint Louis</b>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Normandy</b> Length of stay in 1b <b>39 days</b>	
c. CITY OR TOWN <b>Saint Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Normandy osteopathic Hosp.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>5335 Conde</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Collier</b> Last <b>Collier</b>	
4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> , Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>
7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1909</b>
9. AGE (last birthday) <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Chrome Craft, Inc.</b>
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U SA</b>
13a. FATHER'S NAME <b>Edward Collier</b>	13b. MOTHER'S MAIDEN NAME <b>Catherine Kaiser</b>
14. NAME OF HUSBAND OR WIFE <b>Barbara Collier</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>
16. SOCIAL SECURITY NO. <b>64</b>	17. INFORMANT Address <b>Mrs. Barbara Collier, 5335 Conde</b>
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO (b) <b>Generalized Carcinomatosis</b> DUE TO (c) <b>Bronchio genic Carcinoma</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b> <b>10 days</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) <b>1621</b>	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Month, Day, Year a.m. p.m.	
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 <b>October 23, 1962</b> to <b>1-23-63</b> and last saw him/her live on <b>1-24-63</b> Death occurred at <b>1:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>H. Peckery M.D.</b>	22b. ADDRESS <b>2520 Natural Bridge St. Louis 2, Mo</b>
22c. DATE SIGNED <b>1-24-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>1-28-1963</b>
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Stock Mortuaries, 2117 E. Grand</b>	25. DATE RECD. BY LOCAL REG. <b>1-26-63</b>
26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Paul A. Wachtler*

Licensed Embalmer No.

*4287*

P. O. Address

*St. Louis, 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.