MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

33370

File No.

Registered No. 51

1. PLACE OF DEATH
County Dekalb
Township Washington
City (No. , St. Ward)

Registration District No. 258
Primary Registration District No. 5360A

2. FULL NAME Frank Collins

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 10/1881

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	48	0	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY) Dekalb Co., Mo.

PARENTS

10. NAME OF FATHER D.S.Collins

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Indiana

12. MAIDEN NAME OF MOTHER Mary Bartlett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Stewartsville, Mo.

14. INFORMANT H.C.Collins,
(Address) St.Joseph, Mo.

15. FILED ....., 19..... REGISTRAR

V MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 1st 1929

17.
I HEREBY CERTIFY, That I attended deceased from May 16, 19 29, to Sept. 29-1929, 19.....
that I last saw h. im alive on Sept. 29, 19....., and that death occurred, on the date stated above, at 12-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia-Left
C.V.D.
C.V.D.
(duration) yrs. 4 mos. 12 ds.

CONTRIBUTORY (SECONDARY) Cerebral Hem.
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

Oscar L. Perkins
(Signed) Oscar L. Perkins, M. D.
10/3/29 (Address) Clarksdale, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Clarksdale Cemetery
DATE OF BURIAL Oct 3 1929

20. UNDERTAKER C M Davis-Clarksdale Mo
ADDRESS

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County DeKalb Registration District No. 25-8 File No.
Township Washington Primary Registration District No. 5360 a Registered No.
City (No. St. Ward)

2. FULL NAME Frank Collins

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Oct 1, 1929 C. M. Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 1 - 1929

17.
I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at .....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
..... (duration) ....yrs....mos....ds.

CONTRIBUTORY (SECONDARY)
..... (duration) ....yrs....mos....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed)....., M. D.
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

Y ARE COMPLETE AS PRESCRIBED BY LAW

S-33370