

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WILL BE I CANEY, WITH OBTAINING IN THIS IS A PERMANENT RECORD

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

Do not use this space.

JAN 6 1935

1. PLACE OF DEATH

County Douglas
Township McMuley
City McMuley Spgs (No. _____)

Registration District No. 957
Primary Registration District No. 5395

File No. 42497
Registered No. 11
St. _____ Ward _____

2. FULL NAME

Rusha Bell 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

F.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word)

Widow

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

Samuel M. Collins

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

July 13 - 1871

7. AGE

YEARS
63

MONTHS

4

DAYS

22

If LESS than 1
day, _____ hrs.
or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.

House Keeping

(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)

Starter Co Missouri

10. NAME OF FATHER

Lewis Parker

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Georgia

12. MAIDEN NAME OF MOTHER

Christa Butler

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Georgia

14.

INFORMANT

(Address)

Rufus Collins
Willow Springs Mo

15.

FILED

Dec 30 1934 Faye Thornton
REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 5 1934

17.

I HEREBY CERTIFY, That I attended deceased from
November 7 1934 to Dec 5 1934
that I last saw her alive on Dec 5 1934, and that
death occurred, on the date stated above, at 1-15 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Abdominal Disease 9 months
and developed jaundice

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)

also full developed case
Bright's Disease

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

at Home

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no

DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) Dr. J. A. Osborn M. D.

1934 (Address) Wm. and R-1

*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

Carroll Cemetery

Dec 6 1934

20. UNDERTAKER

ADDRESS

Osborn Osborn

Helicon Mo

7-18-1871

~~4-17-1873~~

1734
1871
63

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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 Douglas
Township
City (No.)

Registration District No. 957
Primary Registration District No. 5395

File No. 42497
Registered No. 11
St. Ward

2. FULL NAME

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

PERSONAL AND STATISTICAL PARTICULARS

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

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.
63 4 22

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED Dec 30, 1934 Boye Thornton Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 5, 1934

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 .

I last saw alive on , 19 . Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Assessed Fever Date of onset
Tuberculosis

Other contributory causes of importance: Chronic
Bright's Disease

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury , 19 .

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) , M. D.
(Address)

S-42497