

AUG 23 1937

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

Do not use this space.

27105

## 1. PLACE OF DEATH

County *De Kalb*Township *Sherman*City *Clarksdale*

(No. ....)

Registration District No. *258*Primary Registration District No. *6361*

File No. ....

Registered No. *7*

St. ....

Ward) .....

2. FULL NAME *Carol Jean 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)

*Female white**Single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 17 - 1937*

7. AGE

YEARS

MONTHS

DAYS

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

*82*

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

~~Spinner~~

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

*None*

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) *De Kalb Co. Mo.*

13. NAME

*Paul J. Collins*14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *De Kalb*15. MAIDEN NAME *Thelma Thornton*16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *De Kalb*17. INFORMANT (ADDRESS) *Paul J. Collins*  
*Clarksdale Mo*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Clarksdale*DATE *July 19*

1937

19. UNDERTAKER (ADDRESS) *John G. Brann*20. FILED *July 19*

1937

Mo

C. M. Davis

Registrar.

Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *7/19/37*

19

22. I HEREBY CERTIFY, That I attended deceased from

*July - 17*, 19*37*, to *July 18*, 19*37*I last saw her alive on *July 18*, 19*37*. Death is saidto have occurred on the date stated above, at *3:30* A.M.

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

*Transition**compression during birth*

Date of onset

Other contributory causes of importance:

Name of operation *none*

Date of .....

What test confirmed diagnosis? *clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? .....

Date of injury .....

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? *no*

If so, specify

(Signed) *D. L. Perkins*

, M. D.

(Address) *Clarksdale Mo*

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.

