

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

2024-1-12-28

1142

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.

FEB 15 1940

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

2502  
Do not use this space.

1. PLACE OF DEATH

(a) County Henry Registration District No. 347

(b) Township D Primary Registration District No. 3018 Registered No. ....

(c) City Clinton (d) Street No. .... (If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME Wm Thomas Collier

(a) Residence, No. 701 N 2nd St St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 26 1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 79 10 4

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

9. Industry or business in which work was done, as 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) Springfield Ill

FATHER

13. NAME Collier

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

MOTHER

15. MAIDEN NAME Algeria Shane

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

17. INFORMANT (ADDRESS) Mrs Mary Collier Clinton mo

18. BURIAL, CREMATION, OR REMOVAL PLACE England DATE 2/1 40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Consolidated Pres Clinton mo

20. FILED 2-3 1940 Dr. J. R. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30 1940

22. I HEREBY CERTIFY, That I attended deceased from June 30 1939 to Jan 30 1940. (last saw h. see alive on Jan 30 1940. Death is said to have occurred on the date stated above, at 1 p. m.

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

apoplexy, lateral sclerosis, Bronchial catarrh

Date of onset

Other contributory causes of importance: 72

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? no  
If so, specify ..... (Signed) Wm T. Collier (Address) Clinton mo

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

STATE TO BE FILED IN

RECEIVED  
District Health Officer No. 1  
District File Number 2-40-294  
Date Filed 2-14-40

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

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**