DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 2843

FILED FEB 7 1946

Registration District No. 7317 Primary Registration District No. 6507 Registrar's No. 9

1. PLACE OF DEATH:
(a) County HENRY
(b) City or town CLINTON Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: DAVIS TWP. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution No (Specify whether
In this community 72 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Clinton
(If outside city or town limits, write "RURAL")
(d) Street No. RR 5 Davis Twp.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME GEORGE N. COLLIER
3. (b) If veteran, name war NONE
3. (c) Social Security No. NONE

4. Sex MALE
5. Color or race W
6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife JENNIE M. COLLIER
6. (c) Age of husband or wife if alive DEAD years
7. Birth date of deceased MARCH (Month) 23 (Day) 1864 (Year)

8. AGE: Years	Months	Days	If less than one day
81	9	15	hr. min.

9. Birthplace Springfield Ill (City, town, or county) (State or foreign country)
10. Usual occupation merchant & Carpenter
11. Industry or business
MOTHER FATHER
12. Name Mose Collier
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Mary M. Anderson
15. Birthplace Ill (City, town, or county) (State or foreign country)
16. (a) Informant Mrs T. E. Reed
(b) Address Clinton R# 5
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation Bayo Creek Cem
18. (a) Signature of funeral director W. S. Vansant
(b) Address Clinton
19. (a) 1-8-46 (Date received local registrar) (b) R. R. Kennedy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1946 hour 5:30 minute A. M.
21. I hereby certify that I attended the deceased from July 4, 1945, to Jan 4, 1946
that I last saw her alive on Jan 4, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature R. J. Powell (M. D. or other) DO
Address Clinton Mo Date signed 1-8-46

120

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RE[illegible]ED
Di[illegible] Office No. 7
Di[illegible] 1-46-28
2-5-46
Date Fil[illegible]

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 *N. L. Vaussant* ....

Licensed Embalmer No. *3779* ....

P. O. Address *Clinton* ....

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, fact should be so stated above.

No. 2B
3-45
X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 137 Primary Registration District No. 5587 Registrar's No. 9

1. **PLACE OF DEATH:**
(a) County Henry
(b) City or town (Rural, Davis Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 7 mi S w. Clinton
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. **USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME George M. Collier

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive Years

7. Birth date of deceased Mar (Month) 23 (Day) 1865 (Year)

8. **AGE:** Years 81 Months 9 Days 15 If less than one day hr. min.

9. Birthplace (City, town, or county) Ill (State or foreign country)

10. Usual occupation

11. Industry or Business

MOTHER / FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Jan day
year 1946 hour 6 minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

7557 WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

2843