V. S. No. 2
300M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5411

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 24

59 / 1 / 2

1. PLACE OF DEATH:
(a) County Livingston
(b) City or town Chillicothe (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Chillicothe Hospital 0 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Days In this community Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 59
(a) State Mo (b) County Living 1
(c) City or town Chillicothe Mo (If outside city or town limits, write "RURAL") 2
(d) Street No. (If rural, give location) 1
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Belle Boyd Collins
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 1
5. Color or race White
6. (a) Single, widowed, married, divorced Widow 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased Sept (Month) 5 (Day) 1890 (Year)

8. AGE: Years	Months	Days	If less than one day
58	5	7	hr. min.

9. Birthplace (City, town, or county) Kansas 1 (State or foreign country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Balzora Hayes
15. Birthplace (City, town, or county) Mo 0 (State or foreign country)

16. (a) Informant Warren Collins
(b) Address Clarksdale Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2 (Month) 15 (Day) 48 (Year)
(c) Place: burial or cremation Clarksdale Mo.
18. (a) Signature of funeral director John Bram
(b) Address Maysville Mo
19. (a) Feb/12/48 (Date received local registrar) (b) Frances B. Neill (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 12 year 1948 hour 3 minute 0 P. M.
21. I hereby certify that I attended the deceased from Feb 8, 1948 to Feb 12, 1948 that I last saw her alive on Feb 12, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral abscess	
Due to Ethmoid & sphenoid sinusitis	
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 0

23. Signature G. W. Carpenter (M. D. or other)
Address Chillicothe Mo Date signed 2/13/48

(Licensed Embalmer's Statement on Reverse Side)

MAR 24 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 John Brown

Licensed Embalmer No. 3933

P. O. Address Maysville, Mo

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.