LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

17724

V. S. No. 2.

MARGIN RESERVED FOR BINDING

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

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.

LACE OF DEATH
County Dunklin — Registration District No. 289 — File No.
Township Cotton Hill — Primary Registration District No. 5407 — Registered No. 49
City ..... (No. ..... St. ..... Ward)

ULL NAME John Martin Cole

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

X	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
le	White	Infant

MARRIED, WIDOWED, OR DIVORCED
USBAND OF
OR) WIFE OF Infant

TE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23rd 1924

E	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	1	5	4	

CUPATION OF DECEASED
) Trade, profession, or rticular kind of work Infant
) General nature of industry, siness, or establishment in hich employed (or employer) Infant
) Name of employer At Home

THPLACE (CITY OR TOWN)
STATE OR COUNTRY) Craighead Co Ark

NAME OF FATHER James V. Cole

BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) Arkansas

MAIDEN NAME OF MOTHER Armer C. ~~Morris~~ Field

BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Monroe Co Ark

FORMANT Bert Mims
ddress) Tallapoosa Mo

ED 6/28, 1925 S. E. Mitchell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 27 1925

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1925, to June 27, 1925 that I last saw him alive on June 27, 1925, and that death occurred, on the date stated above, at 7 P. M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Anterior Polio-Myelitus
16 22
(duration) yrs. 1 mos. ds

CONTRIBUTORY (SECONDARY) ✓
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? ✓
DID AN OPERATION PRECEDE DEATH? No. DATE OF ✓
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) S. E. Mitchell, M. D
6/28, 1925 (Address) Malden Mo

*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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Malden Mo	6/28 1925
20. UNDERTAKER	ADDRESS
W. L. Craig	Malden Mo

LOCAL REGISTRAR'S REPORT—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17.
I HEREBY CERTIFY, That I attended deceased from .....
....., 19....., to .....
that I last saw h..... alive on....., 19.....,
death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?.....
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....
WHAT TEST CONFIRMED DIAGNOSIS?.....
(Signed).....
....., 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

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V. S. No. 2.