

Registration District No. **190-24** Primary Registration District No. **190-264** Registrar's No. **50**

1. PLACE OF DEATH:

(a) County Clark
(b) City or town Medill, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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

3. (a) PRINT FULL NAME Lida Louella Coslett **243**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Calvin P. Coslett 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Nov. 28 1872
(Month) (Day) (Year)

8. AGE: Years 66 Months 10 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Scotland Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
12. Name James Watson
13. Birthplace Scotland Co Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Burns
15. Birthplace Scotland Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Merle Coslett
(b) Address Medill Mo

17. (a) Burial (b) Date thereof Oct 21 13
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bible Grove Mo

18. (a) Signature of funeral director George W. Borket

(b) Address 107 21-38

19. (a) _____ (b) J. R. Braden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clark
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 18 day _____
year 1939 hour 1:30 minute _____ a. 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.

Immediate cause of death Cerebral Hemorrhage
Due to Arterio-Sclerosis

Due to _____
Other conditions SH
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Perry S. Boston (M. D. or other) D.O.
Address Kala Ka, Mo Date signed 10/21/39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED

District Health Officer No. 10

District File Number 11-39-1930

Date Filed NOV 14 1939

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 George O. Barkett

Licensed Embalmer No. 1817

P. O. Address Wyconda, 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, above space should be left blank.