

Registration District No. 1918

Primary Registration District No. 3010

Registrar's No. 10

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Seavern Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hosp. 2 da.
(Specify whether
In this community _____
years, months or days) 24

8. (a) PRINT FULL NAME WITHERS WEBB COLE
8. (b) If veteran, name war no
8. (c) Social Security No. no

4. Sex m.
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Laura Littlejohn
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug 6 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
79 5 15 hr. min.

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

10. Usual occupation farmer

11. Industry or business
MOTHER FATHER
12. Name Jesse Cole
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Wuth Cox
15. Birthplace Dover Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Laura L. Cole
(b) Address Dover Mo

17. (a) Burial (b) Date thereof Jan 23 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dover Mo

18. (a) Signature of funeral director W. J. ...
(b) Address Livingston, Mo.

19. (a) 1-22-40 (b) Wuth Haskins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Carroll
(c) City or town Carrollton
(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 1 day 21
year 1940 hour 8 minute 15 P.M.
21. I hereby certify that I attended the deceased from 1-18-40
to 1-21 1940
that I last saw him alive on 1-21 1940
and that death occurred on the date and hour stated above.

Immediate cause of death ursemia
Due to Chronic Hypertrophy of prostate
Due to _____

Other conditions Chronic Cardiac Valvular
(Include pregnancy within 3 months of death)

Major findings:
Of operations 9/2/40
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? _____

(Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature J. B. Seavern (M. D. or other) MD
Address Carrollton Mo Date signed 1-21-40

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. 8,
District File Number
07/24/40
Date Filed

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 Garrest J. Timpel
Licensed Embalmer No. 3275
P. O. Address Livingston,

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.