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41507

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JAN 11 1943

Registration District No. 270

Primary Registration District No. 3050

Registrar's No. 97

1. PLACE OF DEATH:

(a) County Penicook

(b) City or town Caruthersville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Penicook

(c) City or town Caruthersville  
(If outside city or town limits, write "RURAL")

(d) Street No. 1  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Charles Raymond Cole

3. (b) If veteran, name war: .....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 26th  
year 1942 hour 7 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec. 21 1942 to Dec. 26 1942  
that I last saw him alive on Dec. 25 1942  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife: .....

6. (c) Age of husband or wife if alive 5 years (Day) (Year)

7. Birth date of deceased: Dec. 5 1942  
(Month) (Day) (Year)

Immediate cause of death

Bronchopneumonia 2 days

Influenza 5 days

8. AGE: Years Months Days If less than one day

21 hr. min.

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

10. Usual occupation Infant

11. Industry or business: .....

12. Name Robert B. Cole

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

14. Maiden name Sharon French

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

16. (a) Informant Robert B. Cole

(b) Address Caruthersville

17. (a) Burial (b) Date thereof Dec. 27 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Zion Cemetery, Deeds Mo.

18. (a) Signature of funeral director: .....

(b) Address: .....

19. (a) 12-26-1942 (b) Jessie H. Markey  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) ZZZ

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 J. R. Pinnion (M. D. or other)

Address Caruthersville, Mo. Date signed 12-26-42

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

78  
1  
2

MOTHER FATHER

1206

(Licensed Embalmer's Statement on Reverse Side)

1-19-43

2045 E 5th st

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41507  
Registrar's No. 97

Registration District No. 270

Primary Registration District No. 3050

1. PLACE OF DEATH:

(a) County Peru  
(b) City or town Caruthersville  
(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 Charles R. Cole

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 S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased dec (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ if less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director German Lind Co

(b) Address Steale, mo

19. (a) 12-26-1947 (b) Jessie N. Markey (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month dec year 1947 minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I first saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

[The page contains extremely faint and illegible text, likely bleed-through from the reverse side of the document. The text is arranged in several columns and is mostly unreadable.]

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