

FILED APR 7 1943 70

Registrar's No. **31**

Registration District No. **70**

Primary Registration District No. **5281**

1. PLACE OF DEATH:

(a) County **Clark**  
(b) City or town **Rural Madison**  
(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 **Ada Larine Cole**

3. (b) If veteran, name war  3. (c) Social Security No.

4. Sex **F. M.** 5. Color or race **3 Negro** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **December 25 1889**  
(Month) (Day) (Year)

8. AGE: Years **53** Months **2** Days **18** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Clark Co. Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business \_\_\_\_\_

12. Name **Joseph Cole**

13. Birthplace **Pennsylvania**  
(City, town, or county) (State or foreign country)

14. Maiden name **Matilda Hiattman**

15. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Sam. Hall**

(b) Address **Kaloka Mo. R.F.D.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4-15-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Waterloo Cemetery**

18. (a) Signature of funeral director **Fred J. Charles**

(b) Address **Kaloka Mo.**

19. (a) **3-16-43** (Date received local registrar) (b) **Perry J. Boston** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Clark** **23**  
(c) City or town **Rural Madison Twp.** **3**  
(If outside city or town limits, write "RURAL") (If rural, give location)  
(d) Street No. \_\_\_\_\_  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **13th** year **1943** hour **2** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **March 12 1943**, to **March 13 1943**, that I last saw her alive on **May 12 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic Pneu.** **Duration**

Due to **Fibroid tumor and Chronic Poliomyelitis** **yes**

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (c) Means of injury **2**

23. Signature **P. S. Burton** (M.D. or other) **Do**

Address **Kaloka Mo.** Date signed \_\_\_\_\_

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

MOTHER FATHER

1073

(Licensed Embalmer's Statement on Reverse Side)

3757B

8211

RECEIVED

District Health Officer No. 10

District File Number 4-43-610

Date Filed MAR 15 1943

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 Fred J. Karle  
Licensed Embalmer No. 1023  
P. O. Address Kahoka 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 9954  
Registrar's No. 91

Registration District No. 70

Primary Registration District No. 5281

1. PLACE OF DEATH:

(a) County Clark

(b) City or town Rural  
(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 years, months or days)

In this community \_\_\_\_\_  
(Specify whether years, months or days)

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 \_\_\_\_\_

3. (a) PRINT FULL NAME ada Lavinie Cole

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color of race B 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 25  
(Month) (Day) (Year)

8. AGE: Years 53 Months 2 Days \_\_\_\_\_  
(If less than one day min.)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry of business \_\_\_\_\_

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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Suprasternal lymph node, lobar fibrous tumor  
Due to and chronic poliomyelitis

Other conditions \_\_\_\_\_  
(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? \_\_\_\_\_

23. Signature Perry S. Barton (M. D. or other) Do  
Address Kahokoma Date signed \_\_\_\_\_

Duration 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

