

FILED JAN 7 1944

Registration District No. 7

Primary Registration District No. 5319

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Cooper
(b) City or town Rural
(c) Name of hospital or institution Otter Twp. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper
(c) City or town Rural
(If outside city or town limits, write "RURAL.")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Holbert Cole

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

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife deceased 6. (c) Age of husband or wife if alive 31 years
7. Birth date of deceased Sept 18 - 1860
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 12 day 31
year 1943 hour 6-30 minute P.M.

21. I hereby certify that I attended the deceased from Dec 28 to Dec 31, 1943
that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Influenza
Duration 3 days

8. AGE: Years 83 Months 3 Days 13 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

12. Name Stance Cole

13. Birthplace Cooper Co Mo (City, town, or county) (State or foreign country)

14. Maiden name Do not know

15. Birthplace Cooper Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant Parter Cole

(b) Address Flareice Mo

17. (a) Burial (Burial, cremation, or removal) Burial (b) Date thereof 1-2-44 (Month) (Day) (Year)

(c) Place: burial or cremation W. Hebo-Cooper Co Mo

18. (a) Signature of funeral director A. F. Neumyer

(b) Address Amblinton Mo

19. (a) Jan 4-1944 (Date received local registrar) (b) Mrs. W. R. Tolien (Registrar's signature)

Due to _____
Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death) Robert Fogel PHYSICIAN
Major findings: Of operations

Of autopsy PS
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) (e) Means of injury _____

23. Signature Robert Fogel (M. D. or other) 11/44

Address Otterville Date signed _____

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number _____
Date Filed 1-24-44

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 A. F. Neumeier
Licensed Embalmer No. 13912
P. O. Address Smiths Md

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.