

X35697

FILED MAY 8 1944
Registration District No. **902**

Primary Registration District No. **5331**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County DADE
(b) City or town CEDAR TOWNSHIP
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7 Mi. N.W. of LOCKWOOD
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NONE (Specify whether
In this community 62 YEARS years, months or days)

3. (a) PRINT FULL NAME LOTTIE BELL COLE
3. (b) If veteran, name war No **3. (c) Social Security** No. No

4. Sex FEMALE **5. Color or race** WHITE **6. (a) Single, widowed, married,** divorced MARRIED
6. (b) Name of husband or wife WILLIAM H. COLE **6. (c) Age of husband or wife if** alive 17 years
7. Birth date of deceased APRIL 17 1881
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 24 If less than one day
hr. _____ min. _____

9. Birthplace DADE CO. MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE
11. Industry or business HOME

12. Name WILLIAM B. SHARP
13. Birthplace No RECORD 9
(City, town, or county) (State or foreign country)
14. Maiden name LETA BERRY
15. Birthplace No RECORD 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Wm. G. Cole
(b) Address Lockwood R#1, Mo.
17. (a) BURIAL **(b) Date thereof** 4-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NEW BETHEL CEMETERY

18. (a) Signature of funeral director Ward Funeral Home
(b) Address Summit Mo.
19. (a) April 12, 1944 **(b)** Wm. G. Cole
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County DADE
(c) City or town 7 Mi. N.W. LOCKWOOD
(If outside city or town limits, write "RURAL")
(d) Street No. No (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10
year 1944 hour 11 minute 08 A.M.
21. I hereby certify that I attended the deceased from April 9
1944 to April 10 1944
that I last saw her alive on April 10 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency
Duration _____

Due to Post operative Embolism

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)
(e) Means of injury _____
23. Signature Raymond A. Carlson (M. D. or other) 2
Stellen City, Mo. Address _____ Date signed 4/11/44

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

RECEIVED

District Health Officer No. 6,
District File Number 544-526

Date Filed MAY 4 1944

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 Sam E. Seneaney

Licensed Embalmer No. 4099

P. O. Address Greenfield 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May
Registrar's No. _____

Registration District No. 92 Primary Registration District No. 5331

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

1. PLACE OF DEATH:

(a) County Osceola
(b) City or town Cedar Township 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
In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Lettie Bell Cole

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased April 17 1885
(Month) (Day) (Year)

8. AGE: Years 62 Months 11 Days 2 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or 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)

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 April year 1948 day _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death Cardiac insufficiency Duration _____

Due to Postoperative Embolism

Due to Collapsed Aorta

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? _____

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

23. Signature Raymond Perkins _____ (or other) _____
Address Golden City Mo. Date signed 5-15-48

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

14524