

FILED SEP 2 1944
Registration District No. _____

Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan

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

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

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

In this community 1 year
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2208 Francis Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Romain Harold Cole

3. (b) If veteran, name war No

3. (c) Social Security No. 079-01-5317

4. Sex male 5. Color or race white

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

6. (b) Name of husband or wife Marion McHugh Cole

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased August 1 1914
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>30</u>	<u>0</u>	<u>4</u>	hr. _____ min. _____

9. Birthplace North Rose New York
(City, town, or county) (State or foreign country)

10. Usual occupation Nurseries

11. Industry or business Mgr. C. W. Stuart Co., Inc.

MOTHER FATHER {

12. Name Romain H. Cole

13. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

14. Maiden name Carrie Tague

15. Birthplace Unknown New York
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. J. Hennessy (Sister)

(b) Address Rochester, New York

17. (a) Removal (b) Date thereof 8/17/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newark, New York State

18. (a) Signature of funeral director Walter McNeiff

(b) Address 1302 Faraon St. Joseph, Miss. Mo.

19. (a) 8/17/44 (b) Helen A. Tinkle
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15th
year 1944 hour 7 minute 10 P. M.

21. I hereby certify that I attended the deceased from Aug 9th
1944 to Aug 15th 1944

that I last saw him alive on Aug 15th 1944
and that death occurred on the date and hour stated above.

Immediate cause of death acute peritonitis Duration 5 da.

Due to ruptured appendix 5 da.

Due to _____

Other conditions 12/11
(Include pregnancy within 3 months of death)

Major findings: Pus in abdomen
Of operations gangrenous appendix

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) no

(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 _____

23. Signature H. D. Kearby (M. D. or other) _____
Address St Joseph Mo. Date signed 8-16-44

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

1377

SEP 8 1944

OCT 8 1945

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

Albert C. Harrington

Licensed Embalmer No. 3258 Missouri

P. O. Address St. Joseph, Missouri.

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.