

S. No. 2
DM-542
v. 5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2942**

FILED JAN 22 1945

Registration District No. **239**

Primary Registration District No. **58-25-4356**

Registrar's No. **4356**

1. PLACE OF DEATH:

(a) County **New Madrid**
(b) City or town **Parma**
(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 **Two weeks**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Butler**
(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 **Andrew J. Cole**

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

4. Sex **male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Minnie Cole**
6. (c) Age of husband or wife if alive **62** years
7. Birth date of deceased **January 4, 1872**
(Month) (Day) (Year)

8. AGE: Years **72** Months **11** Days **21**
If less than one day hr. _____ min. _____

9. Birthplace **Paducah, Walosh Co., Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **William Cole**

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

14. Maiden name **May**

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

16. (a) Informant **Minnie Cole**

(b) Address **Parma Mo**

17. (a) **Burial** (b) Date thereof **12-26-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Thomas C. Knight**

(b) Address **Parma Mo**

19. (a) **Jan 5/45** (b) **Mrs. S.B. Rademaker**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **25**
year **1944** hour **one** minute **11** M.

21. I hereby certify that I attended the deceased from **Dec 20**
1944 to **Dec 25** 1944
that I last saw him alive on **Dec 23** 1944
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

Due to _____
Due to **87a**

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 **Geo. W. Husted M.D.** (M. D. or other)
Address **Parma Mo** Date signed **Jan 4, 1945**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

72
5
0

1028

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Office No. 2,

District File Number 145-76

Date Filed 1-16-45

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 Thomas C. Knight
Licensed Embalmer No. 2189
P. O. Address Parma, Ohio

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.