S. No. 2
M—1-4-41
v. 5-17-39
I X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 9 1945

Registration District No. 128

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

O'Reilly General Hospital, Mo.

State File No. 9645

Primary Registration District No. 2000

Registrar's No. 269

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution: O'Reilly General Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 102 days (Specify whether
In this community 102 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County Adair

(c) City or town Gradyville
(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 NEWMAN L COLE

3. (b) If veteran, name war WORLD WAR II

3. (c) Social Security No. 406-20-0288

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife None

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

7. Birth date of deceased August (Month) 12, (Day) 1923 (Year)

8. AGE: Years 21 Months 6 Days 20 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business Farming

FATHER
12. Name Henry F. Cole
13. Birthplace Weed (City, town, or county) Kentucky (State or foreign country)

MOTHER
14. Maiden name Ora E. Reese
15. Birthplace Nell (City, town, or county) Kentucky (State or foreign country)

16. (a) Informant Sylvester Cole
(b) Address 7540 W 61 Pl Argo Ill

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Apr. 2, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Breeding, Kentucky

18. (a) Signature of funeral director [signature]
(b) Address Spfd., Mo.

19. (a) 3-31-45 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1945 hour 3 minute 25 A.M.

21. I hereby certify that I attended the deceased from December 20, 1945, to March 31, 1945; that I last saw him alive on March 31, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral thrombosis	2 wks.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Penetrating wounds, severe, left lower abdominal quadrant, incurred in action against the enemy.	
Major findings: Of operations 12 Mar 45--Adhesions and intestinal obstruction	
Of autopsy Findings incomplete	

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

23. Signature [signature] Capt MC (M.D. or other)
Address O'Reilly Gen Hosp Date signed 31 Mar 45

(Licensed Embalmer's Statement on Reverse Side)

Spfd., Mo.

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 .....

Licensed Embalmer No. 2459

P. O. Address .....

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.