. S. No. 2
0M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30538

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 772

39
2
6

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: SPRINGFIELD CITY HOSPITAL
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County GREENE 39

(c) City or town SPRINGFIELD
(If outside city or town limits, write "RURAL")

(d) Street No. 612 S. CAMPBELL AVE. 6
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME EUGENE COLE

3. (b) If veteran, name war NONE

3. (c) Social Security No. UNK.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife RUTH COLE

6. (c) Age of husband or wife if alive 26 years

7. Birth date of deceased March (Month) 12, (Day) 1914 (Year)

8. AGE: Years 31 Months 6 Days 15 If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business Laborer

FATHER
12. Name Grover Cole
13. Birthplace Unk. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Gertrude Householder
15. Birthplace Unk. (City, town, or county) Ill. (State or foreign country)

16. (a) Informant Ruth Cole
(b) Address Springfield, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-45 (Month) (Day) (Year)
(c) Place: burial or cremation East Lawn Cem Springfield Mo.

18. (a) Signature of funeral director T. W. Klingner & Co.
(b) Address ~~Springfield~~

19. (a) 9-29-45 (Date received local registrar) (b) W. E. Handley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 27th year 1945 hour 4 minute 45 P. M.

21. I hereby certify that I attended the deceased from 9/27, 1945, to 9/27, 1945 that I last saw him alive on 9/27, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage

Due to automobile accident Non-Collision- (Speeding)

~~Due to~~ Car turned over several times.

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

Duration

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) accident 133

(b) Date of occurrence 9/27/45

(c) Where did injury occur? Rural Springfield (City or town) Greene (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Highway - S Campbell Road (Specify type of place)

While at work? No (e) Means of injury automobile

23. Signature W. Roland Langston (M. D. or other) MD

Address Springfield, Mo. Date signed 9/28/45

7 84

(Licensed Embalmer's Statement on Reverse Side)

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.....

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.