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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26705

State File No.

Registration District No. 96

Primary Registration District No. 5356

Registrar's No. 51

1. PLACE OF DEATH:

(a) County... Dallas

(b) City or town... Louptane 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 11 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas

(c) City or town... Louptane rural
(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 _____

3. (a) PRINT FULL NAME WILLIAM OLIVER COLE

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4
year 1946 hour _____ minute 15 P.M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____;
that I last saw h. _____ alive on _____ 19 _____;
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color of hair White

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

6. (b) Name of husband or wife Sda 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased: Oct 16 1861
(Month) (Day) (Year)

Immediate cause of death suicide
self-inflicted
gun shot wound
in head

Due to _____

Due to _____

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

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>9</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace Smith Co Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name Mose Cole

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

14. Maiden name _____

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

16. (a) Informant Sda Cole

(b) Address Louptane Mo

17. (a) removed (b) Date thereof 8-7-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Smith Center Mo

18. (a) Signature of funeral director L B Jones

(b) Address Buffalo Mo

19. (a) Aug 12 1946 (b) W. H. Jones
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, all 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 gun

23. Signature W. H. Jones
Address Buffalo Mo Date signed Aug 12 1946

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

MOTHER FATHER

80

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

City and Health Officer No. 71

License No. 7-46-870

Date Filed 8-23-46

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 Marie B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, N.Y.

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.

Registration District No. 96 Primary Registration District No. 5356

1. PLACE OF DEATH:
(a) County Dallas
(b) City or town 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)

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 _____

3. (a) PRINT FULL NAME William O. Cole
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced M
7. Birth date of deceased: Oct 16
(Month) (Day) (Year)

Duration _____
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

8. AGE: Years 44 Months _____ Days _____
If less than one day _____ hr. _____ min.
9. Birthplace Kansas
(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)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Suicide
(b) Date of occurrence 8-4-46
(c) Where did injury occur Loufan Dallas Co.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
about home on farm
While at work? _____ (Specify type of place)
(e) Means of injury shotgun
23. Signature L B Jones (M. D. or other) Coroner
Address Buffalo Mo Date signed 8-30-46

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

SUPPLEMENTARY

MOTHER FATHER

26705