

FILED FEB 10 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2252

1003

Registrar's No. 926

Registration District No. 318

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
 (b) City or town ST LOUIS
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
MISSOURI BAPTIST Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 DAYS
 (Specify whether _____)
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME THOMAS COLN

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

4. Sex M 5. Color or race W 6. (a) Single, widowed; married, divorced Widowed

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

7. Birth date of deceased JAN 5 1862
(Month) (Day) (Year)8. AGE: 85 Years 84 Months 0 Days 18 If less than one day _____ hr. _____ min.9. Birthplace _____ TENN
(City, town, or county) (State or foreign country)10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER
 12. Name NATHAN COLN
 13. Birthplace UNKNOWN
 (City, town, or county) (State or foreign country)
 14. Maiden name UNKNOWN
 15. Birthplace UNKNOWN
 (City, town, or county) (State or foreign country)

16. (a) Informant MR I C COLN
(b) Address KENNETH Mo - 710 E. 5th St.17. (a) REMOVAL (b) Date thereof 1 25 1947
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation PROVIDENCE Cem. Ark.18. (a) Signature of funeral director IRBY FUNERAL HOME(b) Address RECTOR, ARK.19. (a) JAN 28 1947 (b) J. F. Brewer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DUNKLIN 35
 (c) City or town KENNETH
 (If outside city or town limits, write "RURAL") NR 2
 (d) Street No. 710 E. 5th St.
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1-23-47
year _____ hour 5 minute 15 M.21. I hereby certify that I attended the deceased from 1-15-47 to 1-23-47, 1947
that I last saw him alive on 1-23-47, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Coronary OcclusionDue to ArteriosclerosisDue to CentralDue to Stroke

Other conditions (Include pregnancy within 3 months of death)

Major findings:

- Of operations _____

Of autopsy X

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? _____

(e) While at work? _____ (Specify type of place)

(f) Means of injury 1-23-4723. Signature R. E. ... (M. D. or other) 1-23-47Address 432 ... Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

926

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.....

Ronald Yahrke

Licensed Embalmer No. *3917*

P. O. Address *St. Louis Mo.*

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. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(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)

3. (a) PRINT FULL NAME

Thomas Cole

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 85 Months _____ Days _____ (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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)

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) 4-9-48 (b) J. F. Brade
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January
 year 1948 day _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;

that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above,
 immediate cause of death _____

Duration

_____ coronary occlusion

Due to _____ Sen. sclerosis
Arteriosclerosis

Due to _____

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

Major findings: Of operations _____

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) _____
 (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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____



