

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19016

BIRTH NO. _____		REG. DIST. NO. <u>91</u>		PRIMARY REG. DIST. NO. <u>5330</u>		Registrar's No. <u>7</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>Crawford</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Dillard Osage</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Crawford</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION _____		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Dillard, Mo</u>		d. STREET ADDRESS (If rural, give location); _____	
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>William</u>	b. (Middle) <u>R.</u>	c. (Last) <u>Cottrell</u>	(Month) <u>5</u>	(Day) <u>4</u>	(Year) <u>1949</u>	M	F
(Type or Print)							
6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>		8. DATE OF BIRTH <u>6-27-1872</u>		9. AGE (In years last birthday) <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Mech.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>man</u>		11. BIRTHPLACE (State or foreign country) <u>Osage, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13a. FATHER'S NAME <u>Joseph Dillard Cottrell</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Mason</u>			14. NAME OF HUSBAND OR WIFE <u>Cora Bell Cottrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>x No.</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Cletis Cottrell</u>		
18. CAUSE OF DEATH			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Valvular disease</u>				
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES				
			DUE TO (b) <u>of heart</u>				
			DUE TO (c) _____				
			II. OTHER SIGNIFICANT CONDITIONS				4214
			Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>40</u> , to <u>May 4</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>49</u> , and that death occurred at <u>3 a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>R. L. Parker</u>				23b. ADDRESS <u>M. D. Steelville Mo</u>		23c. DATE SIGNED <u>6-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>5-6-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		24d. LOCATION (City, town, or county) X _____ (State) _____	
DATE REC'D BY LOCAL REG. <u>June 4, 49</u>		REGISTRAR'S SIGNATURE <u>Elsie Hanson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Jones & Son</u>		ADDRESS <u>Steelville Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

28
00

RECEIVED 6/9/49

District Health Officer No. 5,

District File Number 649440

Date Filed 6/16/49

AUG 20 1951

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

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.