

FILED JUL 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24697  
Registrar's No. 6151

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 24697		Registrar's No. 6151		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Francois						
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis			c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) Desloge			48			
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital				e. STREET ADDRESS WK 401 So. Grant		(If rural, give location)				
3. NAME OF DECEASED (Type or Print)		a. (First) Anna		b. (Middle) Narcissa		c. (Last) Cole		4. DATE OF DEATH (Month) (Day) (Year) July 12 1949		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH Sept. 26, 1874		9. AGE (to years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Valley Mines, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13a. FATHER'S NAME Charles East			13b. MOTHER'S MAIDEN NAME Elizabeth Cherry			14. NAME OF HUSBAND OR WIFE Bruce Cole				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. Melton Cole, Desloge, Mo.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative Hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 4 hours	
ANTECEDENT CAUSES				DUE TO (b) Cancer of Right Kidney					2 Years	
DUE TO (c) Hydrocephalus				5 years						
II. OTHER SIGNIFICANT CONDITIONS				Calculi of right kidney					5 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 522						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 180X						
22. I hereby certify that I attended the deceased from June 30, 1949, to July 12, 1949, that I last saw the deceased alive on July 22, 1949, and that death occurred at 3:10 p.m., from the causes and on the date stated above.										
23a. SIGNATURE FR Bradley (Degree or title) M.D.				23b. ADDRESS Barnes Hospital,				23c. DATE SIGNED 7/12/49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-13-49		24c. NAME OF CEMETERY OR CREMATORY Bonne Terre		24d. LOCATION (City, town, or county) (State) Bonne Terre, Mo.				
DATE REC'D BY LOCAL REG. JUL 14 1949		REGISTRAR'S SIGNATURE J. B. Foster			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd					

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

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.

Student .....  
Student Embalmer

Signed *Clement M. May* .....

Licensed Embalmer No. *3733* .....

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

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.