

FILED APR 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

File No. **7458**
State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>1</u>		PRIMARY REG. DIST. NO. <u>3900</u>		Registrar's No. <u>78</u>	
1. PLACE OF DEATH a. COUNTY <u>Adair</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Knox</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kirksville</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Hurdland 0520</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>K. C. O. S. Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ollie</u> b. (Middle) c. (Last) <u>Coleman</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 27, 1950</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 23, 1879</u>	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months Days		IF UNDER 2 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Knox Co., Missouri 6</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>James R. Musgrove</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Sparks</u>		14. NAME OF HUSBAND OR WIFE <u>Charles R. Coleman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Charles R. Coleman, Hurdland, Missouri</u>		
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) <u>Cirrhosis of Liver</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cholecystectomy</u>						<u>5810</u> <u>12 days</u>	
19a. DATE OF OPERATION <u>3-15-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cirrhosis of Liver -- Cholecystitis, chronic</u>				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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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>3-10</u> , 19 <u>50</u> , to <u>3-27</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>3-27</u> , 19 <u>50</u> , and that death occurred at <u>1:43 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>Kirksville Mo</u>		23c. DATE SIGNED <u>3-27-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/29/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Musgrove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>8 Mi. S.E. Brashear, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>3-29-50</u>		REGISTRAR'S SIGNATURE <u>Kate Lambert</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] Hurdland Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

8073
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RECEIVED APR 3 1950
District Health Officer No. _____
District File Number 4-50-57
Date Filed APR 3 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Gertrude Easley Jr.

Signed.....

Student Embalmer

Licensed Embalmer No. 3755

P. O. Address Hurdland 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.