

FILED JAN 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43462

BIRTH NO. _____		REG. DIST. NO. 374		PRIMARY REG. DIST. NO. 6276		Registrar's No. 3	
1. PLACE OF DEATH a. COUNTY Worth				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Worth 1130			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Sheridan 0			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) Lafayette				a. (First) Cossins		b. (Middle)	
c. (Last)				4. DATE OF DEATH 12 26 1950		5. (Month) (Day) (Year)	
5. SEX male 0		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH 8 24 1871	
9. AGE (In years last birthday) 79		10. UNDER 1 YEAR Months 4 Days 2		11. BIRTHPLACE (State or foreign country) Sheridan, Mo. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Samuel Cossins		13b. MOTHER'S MAIDEN NAME Mary Ann McCall		14. NAME OF HUSBAND OR WIFE Mary Etta Cossins			
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 Clarence Cossins ADDRESS Sheridan, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X				INTERVAL BETWEEN ONSET AND DEATH 2 days	
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) m.		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 12-24, 1950 , to 12-26, 1950 , that I last saw the deceased alive on 12-26, 1950 , and that death occurred at 4:00 m., from the causes and on the date stated above.							
23a. SIGNATURE Sharon M. D. (Degree or title) 0				23b. ADDRESS Grant City, Mo.		23c. DATE SIGNED 12-27-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) buried		24b. DATE 12-30-1950		24c. NAME OF CEMETERY OR CREMATORY Sheridan Cemetery		24d. LOCATION (City, town, or county) (State) Sheridan, Mo.	
DATE REC'D BY LOCAL REG. Jan. 4, 1951		REGISTRAR'S SIGNATURE Letta E. Dawson 345		25. FUNERAL DIRECTOR'S SIGNATURE Arch C. Dunfee		ADDRESS Grant City, Mo.	

(Licensed Embalmers' Statement on Reverse Side)

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 Arch C. Dumble

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.