

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32325**

No. 300  
10.48

FILED SEP 26 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 956 PRIMARY REG. DIST. NO. 6209 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Tx</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, write BURAL and give township) <u>Rural Grey</u>	c. LENGTH OF STAY (in this place) <u>Life</u>	c. CITY (If outside corporate limits, write BURAL and give township) <u>Rural Grey</u> <sup>1030</sup>	
d. FULL NAME OF (If not in hospital or institution, give street address of location) <u>HOSPITAL OR INSTITUTION</u>		d. STREET ADDRESS (If rural, give location) <u>8 mi N.E. of Houston, Tx.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>ADAM</u> b. (Middle) <u>ESTREL</u> c. (Last) <u>COLE</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>9 10 51</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 2, 1882</u>	9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Oklahoma City, Okla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	

13a. FATHER'S NAME <u>Adam Cole</u>	13b. MOTHER'S MAIDEN NAME <u>Sarah Turner</u>	14. NAME OF HUSBAND OR WIFE <u>Delilah</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. <u></u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Delilah Cole Houston, Tx.</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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hr</u> <u>Known</u> <u>3 years</u>  <u>30 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Apoplexy</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Essential hypertension</u> DUE TO (c) <u>Obesity</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obesity</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>334 X</u>	20. AUTOPSY? YES <input 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)	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 4-1, 1950, to 9-10, 1951 that I last saw the deceased alive on 4-16, 1951, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Typed or title) <u>Scott G Kramer M.D.</u>	23b. ADDRESS <u>Houston, Mo</u>	23c. DATE SIGNED <u>9-11-51</u>
---	------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>	24b. DATE <u>9-13-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Texas, Co</u> <u>Mo.</u>
--	-----------------------------	---	--

DATE REC'D BY LOCAL REG. <u>Sept 18-51</u>	REGISTRAR'S SIGNATURE <u>Myrtle Craig</u> <sup>327</sup>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dayton D. Elliott Houston, Mo</u>
---	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

070

DIVISION OF HEALTH OF MO.  
District No. 5 - Springfield

RECEIVED

SEP 21 1951

Dist. File

957-1204

Date Filed

9-21-51

---

---

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

*Frank E. Wood*

Licensed Embalmer No.

4026

P. O. Address

*Houston, 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.