

FILED FEB 20 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 44310

BIRTH NO. _____ REG. DIST. NO. 254 PRIMARY REG. DIST. NO. 4386 Registrar's No. 21

1. PLACE OF DEATH a. COUNTY Oregon		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Oregon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Thayer		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Alton	
c. LENGTH OF STAY (in this place) 5 weeks		d. STREET ADDRESS (If rural, give location) 0750	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) MELCINA	b. (Middle) BELLE	c. (Last) COBLE	11 7 1951		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 29, 1879	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 8 Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Jim Wilkerson	13b. MOTHER'S MAIDEN NAME Susan Hall	14. NAME OF HUSBAND OR WIFE Sylvester E. Coble
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Failure DUE TO (c) + recent Anger - Stress Sensitivity		
II. OTHER SIGNIFICANT CONDITIONS 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 type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from Sept 1, 1951, to Nov 7, 1951, that I last saw the deceased alive on Nov 7, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE DW Cooper (Degree or title) DMD	23b. ADDRESS	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 9, 1951	24c. NAME OF CEMETERY OR CREMATORY Myrna Cemetery	24d. LOCATION (City, town, or county) (State) Alton, No. (Rural)
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DATE REC'D BY LOCAL REG. Feb 19	REGISTRAR'S SIGNATURE Arthur Wolff	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Roland Carter Thayer Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

150

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.....

Seland Carter

Signed.....

Student Embalmer

Licensed Embalmer No. 4516

P. O. Address 2 Mayer 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.