

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30702**
Registrar's No. **8153**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Christian	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Taylorville	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) ---	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			

3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) Etta c. (Last) Cole			4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1955		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb. 1st 1911		9. AGE (In years last birthday) 44		10. IF UNDER 1 YEAR: Months _____ Days _____	
11. IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) Danville, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress		10b. KIND OF BUSINESS OR INDUSTRY			

13a. FATHER'S NAME Thomas H. Wallace		13b. MOTHER'S MAIDEN NAME Maise Hubbard		14. NAME OF HUSBAND OR WIFE Ray Cole	
---	--	--	--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT'S SIGNATURE OR NAME Mary Ann Cole, 6400 St. Louis, Ave.	
---	--	-------------------------------------	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema		II. OTHER SIGNIFICANT CONDITIONS			32 Yrs.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES			
		DUE TO (b) Rheumatic Heart Disease			
		DUE TO (c)			
		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 416x		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) (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 **Sept. 12, 1955**, to **Sept. 15, 1955**, that I last saw the deceased alive on **Sept. 15, 1955**, and that death occurred at **5:00P m.**, from the causes and on the date stated above.

23a. SIGNATURE C. P. Vermillion, M.D. (Degree or title) M. D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 9/16/55	
---	--	-------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-16-55		24c. NAME OF CEMETERY OR CREMATORY Local	
				24d. LOCATION (City, town, or county) (State) Georgetown, Ill.	

DATE REC'D BY LOCAL REG. SEP 16 1955		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington.	
---	--	--	--	--	--

mss. (Licensed Embalmer's 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.....
Signature of Student Embalmer

Signed.....
Paul C Waechter

Licensed Embalmer No. *479*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.