

FILED DEC 21 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41077

State File No.

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 2001 Registrar's No. 526

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY Jasper	
b. CITY (If outside corporate limits, write RURAL and give township) Joplin		c. LENGTH OF STAY (In this place) 2 wks.		c. CITY OR TOWN Carl Junction, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Freeman Hospital		e. STREET ADDRESS (If rural, give location) So. Main Street		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JENNIE	b. (Middle) MARIE	c. (Last) GORE	(Month) 12	(Day) 9	(Year) 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-7-1896	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months 4 Days 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) Effingham, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Abraham Rader		13b. MOTHER'S MAIDEN NAME Nancy Ferrell		14. NAME OF HUSBAND OR WIFE Samuel Gore (deceased)	
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. None		17. INFORMANT'S SIGNATURE OR NAME Elsie Frasier	
				ADDRESS Carl Junction, Mo.	

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) Uremia		DUPLICATE		2-3 days	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		Years	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertensive Cardio Vascular Disease		Years	
		DUE TO (c) Arteriosclerosis		Years	
II. OTHER SIGNIFICANT CONDITIONS		Fracture of the surgical neck of the right humerus		10-12 days	
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 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)		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 11/25/55, 1955, to 12/9/55, 1955, that I last saw the deceased alive on 12/9/55, 1955, and that death occurred at 5 a.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Thomas W. Salkup M.D.</i>		(Degree or title) M.D.		23b. ADDRESS 321 Frisco Building Joplin, Missouri	
23c. DATE SIGNED 12/12/55		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-12-1955	
24c. NAME OF CEMETERY OR CREMATORY Forest Park Cemetery		24d. LOCATION (City, town, or county) (State) Joplin, Missouri		25. FURNERAL DIRECTOR'S SIGNATURE <i>Don Foley</i>	
DATE REC'D BY LOCAL REG. 12-15-55		REGISTRAR'S SIGNATURE <i>James L. 138</i>		ADDRESS Carl Junction, Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
DEC 17 1955
Jasper County Health Office
County File Number 55-15-87
Date Filed DEC 17 1955

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 Jack C. Simpson
Licensed Embalmer No. 464

P. O. Address Webb City

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.

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STANDARD CERTIFICATE OF DEATH

State File No. **41077**

BIRTH NO. _____ REG. DIST. NO. **156** PRIMARY REG. DIST. NO. **2001** Registrar's No. **526**

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where decedent lived, if institution; otherwise address) a. STATE Missouri b. COUNTY Jasper	
a. CITY OR TOWN Joplin	b. CITY OR TOWN Carl Junction, Mo.	c. LENGTH OF STAY (If not in hospital or institution, give street address or location) 2 wks.	d. & e. Residence within limits of city or town 2-1-56
c. FULL NAME OF HOSPITAL OR INSTITUTION Freeman Hospital		f. STREET ADDRESS So. Main Street	

3. NAME OF DECEASED a. (First) JEROME b. (Middle) MARIE c. (Last) COLE			4. DATE OF DEATH (Month) (Day) (Year) 12-9-1955				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-7-1896 1869	9. AGE (In years less than birthdate) 86	10. HEIGHT (Inches) 5	11. WEIGHT (In pounds) 120	12. CITIZENSHIP OF BIRTH COUNTRY U.S.A.
10a. USUAL OCCUPATION (Give kind of work describing most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Effingham, Illinois		12. CITIZENSHIP OF BIRTH COUNTRY U.S.A.	

13a. FATHER'S NAME Abraham Rader		13b. MOTHER'S MAIDEN NAME Helen Perrell		14. NAME OF HUSBAND OR WIFE JOHN Samuel Cole (deceased)			
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. None		17. INFORMANT'S SIGNATURE OR NAME Elsie Frasier		ADDRESS Carl Junction, Mo.	

18. CAUSE OF DEATH (Enter only immediate cause for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERNAL BETWEEN CORNEAL AND SCLERITIC 2-3 days	
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) during the underlying acute last. DUE TO (b) Hypertensive Cardio Vascular Disease - Years DUE TO (c) Arteriosclerosis - Years			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of the surgical neck of the right humerus		10-12 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		18. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT SUICIDE HOMICIDE (Specify)		21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.)		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21c. TIME (Month) (Day) (Year) (Hour) OF INJURY		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **11/25/55**, 19___ to **12/9/55**, 19___, that I last saw the deceased alive on **12/9/55**, 19___, and that death occurred at **5** a.m., from the causes and on the date stated above.

23. SIGNATURE Thomas S. Salrup M.D.		24. ADDRESS 321 Frisco Building Joplin, Missouri		25. DATE SIGNED 12/12/55	
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26. BURIAL, CREMATION, REINTERMENT (Specify)		27a. DATE 12-12-1955		27b. NAME OF CEMETERY OR CREMATORY Forest Park Cemetery		27c. LOCATION (City, town, or county) (State) Joplin, Missouri	
DATE REC'D BY LOCAL HEALTH DEPARTMENT 12-15-55		28. SIGNATURE OF LOCAL HEALTH DEPARTMENT OFFICIAL Dr. Robert [unclear]		29. ADDRESS OF LOCAL HEALTH DEPARTMENT Carl Junction, Mo.		30. SIGNATURE OF REGISTRAR [unclear]	

dated December 18, 1955. State of MISSOURI. This certificate was prepared and recorded by the Registrar of the State of Missouri, under the authority of the Department of Health, State of Missouri. The information furnished hereon is true and correct to the best of my knowledge and belief. I am a duly qualified and sworn official of the State of Missouri. My commission expires on _____, 1956.