

Health,  
Welfare  
Public  
Service

300  
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. No standard nomenclature in item 18. No symptoms will be listed. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20391

STATE FILE NUMBER

FILED JUL 3 1957

Registration District No. 68 Primary Registration District No. 4119 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <b>Christian</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Dade</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Ozark</b> TOWN			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Greenfield</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>S.E. part of town</b>			Length of stay in lb <b>6 weeks</b>	d. STREET ADDRESS (If outside, give location) <b>333 Carr St.</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Cora Della Trimble</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1876</b>	9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Dade County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Coble</b>				14. MOTHER'S MAIDEN NAME <b>Louann Lollar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Marie Fitzpatrick; Ozark, Mo.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis; coronary posterior</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized (2) Hypertension 4/201</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>13 May 1957</b> to <b>June 1, 1957</b> and last saw her <sup>her</sup> <del>him</del> alive on <b>1 June 1957</b> Death occurred at <b>9:30</b> <sup>p.</sup> <del>a.</del> m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title). <b>J. D. Roper M. D.</b>				22b. ADDRESS <b>Ozark, Mo.</b>		22c. DATE SIGNED <b>4 June 1957</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 4, 1957</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Antioch Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dade County, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>J. C. Canada; Greenfield, Mo.</b>			25. DATE RECD. BY LOCAL REG. <b>June 29, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Loretta Leonard</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, ~~or by~~ ....., Student Embalmer No. ....

working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *J. C. Canada* .....

Licensed Embalmer No. *419*

P. O. Address *Greenfield* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (I 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.