

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-022913  
STATE FILE NUMBER

FILED JUL 9 1958 Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 142

S. 300  
1-57  
0

1. PLACE OF DEATH a. COUNTY <u>RANDOLPH</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MONROE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOBERLY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>DUNCANS BIPIAGE MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>WHITAKER HOSP</u>		Length of stay in, lb <u>3 wks</u>	STREET ADDRESS (If outside, give location) <u>0696 PFD CLARENCE MO</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSIE HULL COLE</u>			4. DATE OF DEATH Month Day Year <u>JUNE 27 1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24 1892</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>HARRISON COUNTY MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13a. FATHER'S NAME <u>DAVID COLE</u>		13b. MOTHER'S MAIDEN NAME <u>MARY TUCKER</u>		14. NAME OF HUSBAND OR WIFE <u>EDITH COLE</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>NO</u>	17. INFORMANT Address <u>EDITH COLE PFD CLARENCE MO</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last. DUE TO (b) <u>Cardiac arrest</u>					
DUE TO (c) <u>Chronic Cardiac Disease of 8 years Duration</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 <u>6/22/58</u> to <u>June 27, 1958</u> and last saw <sup>xx</sup> her alive on <u>6/27/58</u> Death occurred at <u>9:20 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Benjamin D. Sewer 2 D.D.</u>			22b. ADDRESS <u>205 S. 5th. St., Moberly, Mo.</u>		22c. DATE SIGNED <u>6/28/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>UNRHD</u>		23b. DATE <u>6-29-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ASH CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONROE COUNTY MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>Chas. V. Greening Clarence Mo</u>			25. DATE RECD. BY LOCAL REG. <u>6-28-58</u>		REGISTRAR'S SIGNATURE <u>Teal Dowse</u>

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

JUL 1 1958

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 *Charles V. Green*

Licensed Embalmer No. *4625*  
P. O. Address *Clareme*

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.