

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-028128

FILED VS SEP 14 1959 38

Registration District No. \_\_\_\_\_ Primary Registration District No. 3006 Registrar's No. 422

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Boone</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> Length of stay in 1b <u>9 Days</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>M.U. Medical Center</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Randolph</u> c. CITY OR TOWN <u>Moberly</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>Route #2</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Elizabeth Sarah Cottrell</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>9 6 1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-21-1896</u>	<b>9. AGE</b> (last birthday) <u>62</u>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HR</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>At Home</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Hallsville, Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>unknown</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>unknown</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Henry Cottrell</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>493-01-2738</u>		<b>17. INFORMANT</b> Address <u>Chart - M.U. Medical Center, Columbia, Mo</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (d), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS; NEPHROSCLEROSIS</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT SUICIDE HOMICIDE</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour Month, Day, Year a.m. p.m.							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE			
<b>21. I attended the deceased from</b> <u>8/8/59</u> to <u>9/6/59</u> and last saw her <u>alive</u> on <u>9/6/59</u> Death occurred at <u>12:15</u> <u>p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>J.S. Sanders M.D.</u>				<b>22b. ADDRESS</b> <u>J.S. Sanders M.D.</u>		<b>22c. DATE SIGNED</b> <u>9/6/59</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE</b> <u>Sept 8, 1959</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Chapel Grove</u>		<b>23d. ADDRESS</b> <u>U Clark, Mo</u>		
<b>24. FUNERAL DIRECTOR</b> <u>Cater General Home, Moberly, Mo</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>Sept 6 1959</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs R.E. Palmer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 18 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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Jerry R. Carter*

Licensed Embalmer No. 4906

P. O. Address

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