

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036640

FILED VS. OCT 16 1959

157

Registration District No. Primary Registration District No. 3028

Registrar's No. 189

STATE FILE NUMBER

UNRECORDED

| | | | | | | | |
|--|---|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jasper b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage Length of stay in 1b 40 yrs c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 316 S. Fulton Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jasper c. CITY OR TOWN Carthage Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 316 S. Fulton St Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MARTH A Middle JANE Last COLE | | | 4. DATE OF DEATH Month Day Year Oct. 5, 1959 | | | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 3-30-80 | 9. AGE (last birthday) 79 | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (City and state or country) Marshfield, Mo. | | | |
| 12. CITIZEN OF WHAT COUNTRY USA | | 13a. FATHER'S NAME William Canada | | 13b. MOTHER'S MAIDEN NAME Sarah ? | | | |
| 14. NAME OF HUSBAND OR WIFE Robert 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. none | | | |
| 17. INFORMANT Alta Billington, 413 Walnut, Carthage | | Address MO | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>arteriosclerosis, chronic</i> DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 a.m. p.m. Month, Day, Year | | | | | | | |
| 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 10-21-53 to 10-5-59 and last saw her alive on 9-8-59 Death occurred at 8:05 a m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <i>[Signature]</i> MD | | | 22b. ADDRESS Carthage, Mo | | 22c. DATE SIGNED 10-6-59 | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 10-7-59 | 23c. NAME OF CEMETERY OR CREMATORY Park Cemetery | | 23d. LOCATION (City, town, or county) (State) Carthage, Mo | | |
| 24. FUNERAL DIRECTOR ADDRESS Knell Mortuary, Carthage, Mo | | | 25. DATE RECD. BY LOCAL REG. 10-7-57 | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

X

X

X

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 Robert H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage,

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.