

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS JUL 27 1960

-60-026441

Registration District No. 120 Primary Registration District No. 4124 Registrar's No. 54

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Gentry</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Gentry</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>King City</b>		Length of stay in 1b <b>11 yrs.</b>	c. CITY OR TOWN <b>King City</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>Residence</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>401 N. Grand</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>S.</b> Last <b>Cogdill</b>			4. DATE OF DEATH Month <b>July</b> Day <b>19</b> Year <b>1960</b>		
---	--	--	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/97</b>	9. AGE (last birthday) <b>62</b>	IF UNDER 1 YEAR Months <b>62</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
--------------------	-------------------------------	---	---------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (Self Employed)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Goods St.</b>	11. BIRTHPLACE (City and state or country) <b>DeKalb County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
--	--	--	--

13a. FATHER'S NAME <b>John T. Cogdill</b>	13b. MOTHER'S MAIDEN NAME <b>Viola Stewart</b>	14. NAME OF HUSBAND OR WIFE <b>Alta Cogdill</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give dates of service) <b>None</b>	16. SOCIAL SECURITY NO. <b>489 36 2242</b>	17. INFORMANT <b>Mrs. Alta Cogdill, King City, Mo.</b> Address
--	--	--

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>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN.</b>
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <b>CORONARY Thrombosis</b>	<b>30-40 min</b>
	DUE TO (c) <b>Coronary Atherosclerosis</b>	<b>1 yr</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>None</b>	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 <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 <b>8:30</b> a.m. <b>0</b> 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 <b>King City, Mo.</b> COUNTY <b>Mo.</b> STATE <b>Mo.</b>
--	--	---

21. I attended the deceased from **May 1959** to **July 19, 1960** and last saw him alive on **July 19, 1960**  
Death occurred at **8:30 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>[Signature]</b> (Degree or title)	22b. ADDRESS <b>King City, Mo.</b>	22c. DATE SIGNED <b>7-20-60</b>
---	------------------------------------	---------------------------------

23a. BURIAL (Cremation, Removal, Specity) <b>Removal</b>	23b. DATE <b>7/21/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Maysville, Mo.</b>
--	--------------------------	---	---

24. FUNERAL DIRECTOR <b>Harold E. Walden, King City, Mo.</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-20-60</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. L. W. Bare</b>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 29 1960

**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 Harold E. Keadra

Licensed Embalmer No. 4609

P. O. Address King 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.