

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Montpelier	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Enroute City Hospital		d. STREET ADDRESS (If outside, give location) Empire, St.	

3. NAME OF DECEASED (Type or print) First Middle Last George W. Cole			4. DATE OF DEATH Month Day Year Sept. 5, 1960		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/28/1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk	10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (City and state or country) Warrior, Alabama.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Patrick Cole	13b. MOTHER'S MAIDEN NAME Mary Ann McWilliams	14. NAME OF HUSBAND OR WIFE Unknown	

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. 273-16-6968	17. INFORMANT Mrs. H. L. Davenport, Rural Rt. # 1	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Heat Exhaustion		
DUE TO (b) Chronic Coronary Heart Disease		
DUE TO (c) Chronic Arteritis		42:1

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	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Suffered in room at York
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 9 56 Hotel on or about Sept 5, 1960
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hotel	20f. CITY, TOWN, OR LOCATION St Louis Mo	COUNTY	STATE
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Patrick Taylor Carauer	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 9 7 60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-6-60	23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	23d. LOCATION (City, town, or county) (State) Williams Co., Ohio.
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24. FUNERAL DIRECTOR Albert H. Hoppe Inc., 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. SEP 7 1960	26. REGISTRAR'S SIGNATURE Paul Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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, *Stanley F. Sig*

Licensed Embalmer No. *4119*

P. O. Address *S. D.*

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.