

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
 FILED VS NOV 28 1960

-60-042558

STATE FILE NUMBER

Registration District No. 160 Primary Registration District No. 559 Registrar's No. 149

1. PLACE OF DEATH a. COUNTY <u>JEFFERSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>JEFFERSON</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JOACHIM TOWNSHIP</u>		Length of stay in 1b <u>1 MONTH</u>		c. CITY OR TOWN <u>ARNOLD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MOUNTAIN VIEW HOM</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>HIGHWAY V. V.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edith.</u> Middle <u>F.</u> Last <u>Cole.</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14<sup>th</sup></u> Year <u>1960</u>				
5. SEX <u>FEMALE</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>JUNE 6 1884</u>	9. AGE (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>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and state or country) <u>TOWER CITY N. D.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>FRED W FONDA</u>			13b. MOTHER'S MAIDEN NAME <u>IDA LEDUE</u>			14. NAME OF HUSBAND OR WIFE <u>W. B 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.		17. INFORMANT <u>REV. W. B COLE</u> <u>ARNOLD 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>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Parkinsons Disease</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		
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 _____ s.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 <u>10-15-1960</u> to <u>11-14-1960</u> and last saw her alive on <u>11-12-1960</u> . Death occurred at <u>9:35</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>R. D. Arnold, M.D.</u> (Degree or title)				22b. ADDRESS <u>Crystal City, Mo.</u>		22c. DATE SIGNED <u>11-14-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>NOV 16 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BENNETT BRYAN</u>		23d. LOCATION (City, town, or county) (State) <u>BEAUBRADE MO</u>			
24. FUNERAL DIRECTOR <u>HEINIGTAG Imperial Mo.</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-16-60</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 8 1962

**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 Elmer H. Wiegtag

Licensed Embalmer No. 357

P. O. Address Imperial

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.