

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013552

STATE FILE NUMBER

AMENDED FILED APR 17 1961 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 54

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u> Length of stay in 1b		c. CITY OR TOWN <u>Pattersonville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hospital</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Lee</u> Last <u>Cole</u>			4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>61</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wht</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>2-14-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE (last birthday) <u>80</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>
11a. BIRTHPLACE (City and state or country) <u>Salem Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Hartsborn Cole</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Cassey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give War or dates of service)		14. NAME OF HUSBAND OR WIFE <u>Jane Davis Cole</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Jane Cole, Pattersonville Mo.</u> 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) <u>Congestive Heart Failure</u> DUE TO (b) <u>Plural Effusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>12 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile Debilitation</u>			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 <u>-</u> Month, Day, Year <u>-</u>			
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>6-7-1960</u> to <u>3-31-61</u> and last saw him alive on <u>3-31-61</u> Death occurred at <u>1:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Murray T. Pritchard, MD</u>		22b. ADDRESS <u>913 W Main West Plains, Mo</u>	22c. DATE SIGNED <u>4/10/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4-2-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pattersonville Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Pattersonville Mo.</u>
24. GENERAL DIRECTOR ADDRESS <u>Roberts, West Plains</u>		25. DATE RECD. BY LOCAL REG. <u>4-13-61</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Beck</u>

Pritchard

**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 Al. D. Robertson

Licensed Embalmer No. 3432

P. O. Address \_\_\_\_\_

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.