

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-043360

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 852 Primary Registration District No. \_\_\_\_\_ Registrar's No. 122

1. PLACE OF DEATH a. COUNTY <b>Taney</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY <b>Carroll</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Forsythe</b>		Length of stay in 1b <b>few months</b>	c. CITY OR TOWN <b>Urbanette</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>Lakeview Rest Home</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>above</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE COLE</b>			4. DATE OF DEATH Month Day Year <b>November 24, 1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-13-1871</b>	9. AGE (last birthday) <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Louisville, Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Henry C. Ambrose</b>		13b. MOTHER'S MAIDEN NAME <b>Emily Moore</b>		14. NAME OF HUSBAND OR WIFE <b>Edgar Cole</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>T. R. Turner—Reed Springs, Mo.</b>	

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) <b>Hydrostatic Pneumonia</b>		
Conditions, if any, which gave rise to above cause (b), stating the underlying cause last.	DUE TO (b) <b>Coronary Thrombosis</b>	
DUE TO (c) <b>Senility</b>		

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 <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 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 7-19-61 to 11-24-61 and last saw her/him alive on 11-23-61  
 Death occurred at 9:45 P. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Mary King, D.O.</b>	(Degree or title)	22b. ADDRESS <b>Forsythe, Mo.</b>	22c. DATE SIGNED <b>11-27-61</b>
--	-------------------	--------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11-26-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Urbanette, Arkansas</b>
--	------------------------------	---	---

24. FUNERAL DIRECTOR <b>Nelson Funeral Home—Berryville, Ark.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-2-61</b>	26. REGISTRAR'S SIGNATURE <b>Robert Campbell</b>
---	---------	--	---

DATE AMENDED  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
SHOULD READ  
BY AFFIDAVIT OF

110730

**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 Charles M. Wilson

Licensed Embalmer No. 5002

P. O. Address Berryville, Tenn.

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.

3101 1/10