

FEB 29 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.
X 2447

1. PLACE OF DEATH
 County Missouri Registration District No. 547
 Township Marion Primary Registration District No. 3079
 City Hannibal (No. St. Elizabeth) St. 64 Ward

2. FULL NAME William E. Cole
 (a) Residence No. 715 Union St. 4 Ward. (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 12 - 1910
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
18 4 5
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1 - 7 - 1928
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
fractured skull, cause by hitting tree while riding sled.
21 - 11/88 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) 1/88 (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Hannibal, Mo. (STATE OR COUNTRY) mo
 10. NAME OF FATHER John D. Cole
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hannibal (STATE OR COUNTRY) mo
 12. MAIDEN NAME OF MOTHER Bessie Thomas
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) mo (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? 21 - 11 - 1928 - 290
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? no
 WHAT TEST CONFIRMED DIAGNOSIS?
8 (Signed) James O'Honnell coroner
 (Address) Hannibal, mo

14. INFORMANT Mrs. Archy Chupback (Address) Hannibal, mo
 15. FILED 1/8 29 Clatsote # REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Carmel Cem. DATE OF BURIAL 1-9-1928
 20. UNDERTAKER James O'Honnell ADDRESS Hannibal

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important.

64
18

26

Page 1

**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 547

Township Harrison Primary Registration District No. 3029

City Harrison (No.) St. Ward)

File No.

Registered No. 5

2. FULL NAME William E. Cole

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) S.

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 12 - 1910

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>18</u>	<u>3</u>	<u>5</u>	<u>5</u>	

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
- (b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED 1/8 1929 C. E. Stone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 7 1929

17. I HEREBY CERTIFY That I attended deceased from 19....., 19....., and that death occurred, on the date stated above at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D. , 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully checked. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in full, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-2447