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21

DEC 16 1940 534  
Registration District No.

Primary Registration District No. 4319

State File No.

Registrar's No. 19

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Macon

(b) City or town New Cambria  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2  
(Specify whether \_\_\_\_\_)

In this community 50 years  
years, months or days

3. (a) PRINT FULL NAME Charles M. Cole

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Alida

6. (c) Age of husband or wife if alive 83 years

7. Birth date of deceased May 13 1857  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>86</u>	<u>5</u>	<u>20</u>	<u>-</u> hr. <u>-</u> min.

9. Birthplace New York State  
(City, town, county) (State or foreign country)

10. Usual occupation General Merchandise

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name George A. Cole

13. Birthplace New York State  
(City, town, county) (State or foreign country)

14. Maiden name Alida Martin

15. Birthplace New York State  
(City, town, county) (State or foreign country)

16. (a) Informant J. M. Cole

(b) Address New Cambria Mo

17. (a) Buried (b) Date thereof Nov 2 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Cambria County

18. (a) Signature of funeral director H. J. Hillborn

(b) Address New Cambria Mo

19. (a) Dec 8 (b) C. West  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon

(c) City or town New Cambria  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2nd  
year 1940 hour 5 minute P M.

21. I hereby certify that I attended the deceased from Nov 25 1940 to Nov 2 1940  
that I last saw him alive on Nov 2 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis 2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_ 97

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy no

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
846 While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature C. West (M. D. or other) \_\_\_\_\_  
Address New Cambria Mo Date signed Dec 1940

RECEIVED

District Health Officer No. 10

District File Number 12-40-2315

Date Filed DEC 13 1949

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

H. J. Gilleland

Registered Apprentice No.

working under my personal supervision.

Signed

H. J. Gilleland

Licensed Embalmer No.

4019

P. O. Address

New Cambria Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.