

**REC'D MAR. 19 1941**  
Registration District No. **6143**

Primary Registration District No. **6143**

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

**1. PLACE OF DEATH:** Mrs. Saline Ada Cott  
 (a) County **R.F.D. Slater, Mo.**  
 (b) City, or town **R.F.D. Slater, Mo.**  
 (c) Name of hospital or institution: **none**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **none**  
 In this community **all her life** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** Mrs. Lucy Ada Cott  
 (b) If veteran, name war **no**  
 (c) Social Security No. **no**

**4. Sex** female **5. Color or race** white  
**6. (a) Single, widowed, married, divorced** widowed  
**6. (b) Name of husband or wife** none **6. (c) Age of husband or wife if alive** **no** years  
**7. Birth date of deceased** **Jan. 2nd 1871** (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	1	4	hr. min.

**9. Birthplace** Saline Co **Mo.** (City, town, or county) (State or foreign country)  
**10. Usual occupation** at home  
**11. Industry or business**  
**12. Name** Henry Hensick  
**13. Birthplace** Germany (City, town, or county) (State or foreign country)  
**14. Maiden name** Mary Ann Romine (City, town, or county) (State or foreign country)  
**15. Birthplace** Tenn. (City, town, or county) (State or foreign country)  
**16. (a) Informant** Mrs. Lucile Giger Slater, Mo.  
**(b) Address**  
**17. (a) Burial** (Burial, cremation, or removal) **Feb. 9-1941** (b) Date thereof (Month) (Day) (Year)  
**(c) Place: burial or cremation** Hill Brothers  
**18. (a) Signature of funeral director** Slater, Mo.  
**(b) Address**  
**19. (a) (Date received local registrar)** (b) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mo.** (b) County **Saline**  
 (c) City or town **R. F. D. Slater**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **Clayton** (If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? years.

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **Feb.** day **6th** year **1941** hour **5** minute **P.** M.  
**21. I hereby certify that I attended the deceased from** Dec. 26, 1940, to Feb. 6, 1941, that I last saw her alive on Feb. 5, 1941, and that death occurred on the date and hour stated above.

**Immediate cause of death**  
**Carcinoma of Colon**  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death)  
 Major findings:  
 Of operations  
 Of autopsy

**PHYSICIAN**  
 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?  
 (Specify type of place) While at work? (e) Means of injury  
**23. Signature** **Slater** (M. D. or other)  
 Address **Slater, Mo.** Date signed **Br 7-41**

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 3-12-41

**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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Edgar Moore*

Licensed Embalmer No.

4187

P. O. Address

*Slater Mo*

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

Registration District No. 799

Primary Registration District No. 6043

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Clay T.P.  
(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 \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Mrs. Lucy Ada Cott  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 70 Months 1 Days 4 If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-7-41 (b) W. M. Tuttle  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 6  
year 1944 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I saw him/her alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Cause of death \_\_\_\_\_ Duration \_\_\_\_\_

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

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

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

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature C. W. Caldwell (M. D. or other) \_\_\_\_\_

Address Saline Mo. Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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