

S. No. 2
-2-43
-5-17-39
X35697

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43966**

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon
(b) City or town Blairs Craak
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: X /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X
In this community X (Specify, whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME Rebbaka Cole

3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife B.A. Cole 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Feb 14 1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 22 If less than one day hr. min.

9. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business X

12. Name George Patterson

13. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name Cass Chirsman

15. Birthplace Dent Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant B. Cole

(b) Address Midridge Mo

17. (a) Buried (b) Date thereof 12/18/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West York Cem

18. (a) Signature of funeral director [Signature]

(b) Address Salem Mo

19. (a) [Signature] (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 16
year 1943 hour 8 minute 48 PM

21. I hereby certify that I attended the deceased from Aug 11
1943 to Dec 18 1943
that I last saw her alive on Aug 11 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis Duration 1 y

Due to _____

Due to _____

Other conditions: [Signature]
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 A. F. Buzz (M. D. or other)

Address Atchison Mo Date signed 12-20-43

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 14459

Date Filed 1-11-44

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 [Signature].....

Licensed Embalmer No. [Signature].....

P. O. Address [Signature].....

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. **336**

Primary Registration District No. **6136**

Registrar's No.

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Summersville Mo
(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 1 (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Rebbaka Cole

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb 14 - 1914
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days _____ (If less than one day, hr. min.)

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shannon

(c) City or town Summersville Mo
(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 Dec day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw him/her alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-43666