

No. 2-43  
5-17-39  
X 23697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED OCT 9 1945**  
STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

31064

State File No. \_\_\_\_\_

Registration District No. 245

Primary Registration District No. 5837

Registrar's No. 112

**1. PLACE OF DEATH:**

(a) County Neyton

(b) City or town Camp Crowder *111 B. ...*  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
Building 1589  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
in this community 1 Month 13 Days years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Nebraska (b) County 999

(c) City or town Bridgeport 25  
(If outside city or town limits, write "RURAL")

(d) Street No. Box # 1172 (Phone 154) 0  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 2  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Charles H. Cole, jr.

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 Single

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

7. Birth date of deceased July 27 1924  
(Month) (Day) (Year)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Sept day 18  
year 1945 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from the man was  
dead on arrival 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

8. AGE: Years 21 Months 1 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Soldier

11. Industry or business U. S. Army

MOTHER FATHER { 12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Officer's Service Records

(b) Address Camp Crowder, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sep 18, 1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Bridgeport, Nebr.

18. (a) Signature of funeral director Knell Mortuary  
(b) Address Carthage, Mo.

19. (a) Sep 21, 1945 (Date received local registrar) (b) Melvin C. Bowman (Registrar's signature)

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Wound, Lacerated Brain. Duration \_\_\_\_\_

Due to Multiple compound, Comminuted Fractures of Skull.

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

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

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

Of autopsy As above.

**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) Undetermined

(b) Date of occurrence 18 Sep 45

(c) Where did injury occur? Camp Crowder, Neyton, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place.

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

(e) Means of injury Gunshot Wound

23. Signature Donald W. Ingman (M. D. or other) MC  
Address Camp Crowder, Mo. Date signed 9/19/45

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

1482

(Licensed Embalmer's Statement on Reverse Side)

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.....

*Frank W. Kneel Jr*

Registered Apprentice No. *379*

working under my personal supervision.

RECEIVED

OCT 5 1945

District Health Officer No. ....

District File Number *945-175*

Date Filed *OCT 5 1945*

Signed *Emm. L. Kneel*

Licensed Embalmer No. *391*

P. O. Address *Carlsbad*

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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 31064  
Registrar's No. 112

Registration District No. 245

Primary Registration District No. 5837

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

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Camp Crowder, W. Benton  
(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

Charles H. Cole jr

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

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

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased July 21 (Month) (Day) (Year)

8. AGE: Years 21 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Interp, Colorado (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) (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) Melvin C. Bomman (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 \_\_\_\_\_ (day) \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate 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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

