

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 4 1946

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36239**
Registrar's No. **389**

Registration District No. **4**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:
(a) County **Callaway**
(b) City or town **Fulton**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution **Callaway Hospital**
(If not in hospital or institution, write street number and door)
(d) Length of stay: In hospital or institution **5 days**
(Specify whether years, months or days)

3. (a) Full name **Mrs. Verneida F. Cole**
3. (b) If veteran, name war _____
3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **Negro**
6. (a) Name of husband or wife **Amos**
6. (c) Age of husband or wife if alive **53 years**
7. Birth date of deceased **Oct. 1893**
(Month) (Day) (Year)

8. AGE: Years **63** Months **0** Days **24** If less than one day a hr. min.

9. Birthplace **Cole Co. Missouri**
(City, town or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **Allen Kelly**

13. Birthplace **Missouri**
(City, town or county) (State or foreign country)

14. Maiden name **Corra Duncan**

15. Birthplace **Missouri**
(City, town or county) (State or foreign country)

16. (a) Address **112 N. W. 8th Fulton Mo**
(b) Address **South Side Cem. Fulton, Mo**

17. (a) Burial place **South Side Cem. Fulton, Mo**
(b) Date thereof **Dec 2-46**
(Month) (Day) (Year)

18. (a) Signature of funeral director **Ali Belle**
(b) Address **Fulton, Mo**

19. (a) **11-30-1946** (Date received local registrar)
(b) **Joan M. Mankoff** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Callaway**
(c) City or town **Fulton**
(If outside city or town limits, write "RURAL")
(d) Street No. **520 S. W. 9th**
(If not give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov.** day **29** year **1946** hour **2** minutes **55 A. M.**

21. I hereby certify that I attended the deceased from **Nov 14**, 19**46** to **Nov 29**, 19**46**
that I last saw her alive on **Nov 29** and that death occurred on the date and hour stated above.
Immediate cause of death: **Subacute Myocarditis**
Durdion

Due to **Chronic Myocarditis**

Due to **Arterio Sclerosis**
Other conditions **She had Arthritis**
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations: _____
Of autopsy: **abd**

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 **W. J. Crews** (M. D. or other)
Address **Fulton Mo** Date signed **11/30/46**

