

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8573**

FILED MAR 2 - 1953

BIRTH NO. _____ REG. DIST. NO. **369** PRIMARY REG. DIST. NO. **625T** Registrar's No. **1**

1. PLACE OF DEATH a. COUNTY Wayne		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Wayne	
b. CITY OR TOWN Leeper		c. CITY OR TOWN Leeper - Mill Spring Jop	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1110	
d. FULL NAME OF HOSPITAL OR INSTITUTION			
3. NAME OF DECEASED a. (First) THOMAS b. (Middle) EDWARD c. (Last) Cole			4. DATE OF DEATH (Month) Feb. (Day) 11 (Year) 1953
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 7	8. DATE OF BIRTH Sept. 25, 1892
9. AGE (In years last birthday) 80	# UNDER 1 YEAR 4	Days 16	# UNDER 15 MIN. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State of foreign country) Clark Co. Ind.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Tom Cole	13b. MOTHER'S MAIDEN NAME Melina Sparks	14. NAME OF HUSBAND OR WIFE Susie Summers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Best Cole ADDRESS Leeper Mo.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Fracture of right hip 2 days before DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. E9040 21	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) At home	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Wayne Co. Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb. 9, 1953 10 a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell in the plane	
22. I hereby certify that I attended the deceased from 2-9-1953 , to 2-11-1953 , that I last saw the deceased alive on 2-11-1953 , and that death occurred at 6:45 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE Dr. H.G. Bond M.D. (Degree or title)		23b. ADDRESS Bedmont, Mo.	23c. DATE SIGNED 2-12-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-14-53	24c. NAME OF CEMETERY, OR CREMATORY Mill Spring	24d. LOCATION (City, town, or county) (State) Mill Spring, Mo.
DATE REC'D BY LOCAL REG. Feb. 25, 1953	REGISTRAR'S SIGNATURE Hazel Ward	25. FUNERAL DIRECTOR'S SIGNATURE Norman H. Deal ADDRESS Bedmont, Mo.	

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

RECEIVED

FEB 27 1953

WAYNE CO. HEALTH CENTER

FILE No. 253-9

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 _____

working under my personal supervision.

Student Embalmer No. _____

Student _____
Student Embalmer

Signed Norman W. Gish

Licensed Embalmer No. 3387

P. O. Address Redmond, 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.