

FILED NOV 15 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33421

BIRTH NO. _____		REG. DIST. NO. <u>93</u>		PRIMARY REG. DIST. NO. <u>4153</u>		Registrar's No. <u>54-91</u>		
1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Dade</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lockwood Mo</u>		c. LENGTH OF STAY (in this place) <u>3yrs</u>		c. CITY OR TOWN <u>Lockwood Mo</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial hospital</u>				STREET ADDRESS (If rural, give location) <u>0290</u>				
3. NAME OF DECEASED (Type or Print) <u>Edward Lee Cole</u>			a. (First) <u>Edward</u> b. (Middle) <u>Lee</u> c. (Last) <u>Cole</u>			4. DATE OF DEATH <u>Nov. 4 1954</u> (Month) (Day) (Year)		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>June 25, 1878</u>		
9. AGE (in years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u>		IF UNDER 1 HR. Hours <u>9</u> Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer housewife</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Clinton Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Cole</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Byler</u>			14. NAME OF HUSBAND OR WIFE <u>Osa Cole</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>559-94-9933</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Osa Cole Lockwood Mo.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
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) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331X</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>10-30</u> , 19 <u>54</u> , to <u>11-4</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11-4</u> , 19 <u>54</u> , and that death occurred at <u>4:10 P. m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>Max Keilbrunn M.D.</u>				23b. ADDRESS <u>Lockwood, Mo</u>		23c. DATE SIGNED <u>11-5-54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 7, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenfield</u>		24d. LOCATION (City, town, or county) (State) <u>Greenfield Mo</u>		
DATE REC'D BY LOCAL REG. <u>11-6-54</u>		REGISTRAR'S SIGNATURE <u>J. C. Canada 478</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.R. Allison Greenfield Mo.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *W. R. Allison*.....

Licensed Embalmer No. *44*.....

P. O. Address *Greenville*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.