

FILED AUG 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **27539**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6316**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place) 2 Mo.	c. CITY OR TOWN University City 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 Faith Hospital		STREET ADDRESS (If rural, give location) 6604 Etzel Ave.	

3. NAME OF DECEASED (Type or Print) Isa Cole		4. DATE OF DEATH (Month) (Day) (Year) July 21 1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 24 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (City and State or Foreign Country) Granitville Mo.
13a. FATHER'S NAME Charles W. Rennie		13b. MOTHER'S MAIDEN NAME Bridget O'Halloran	14. NAME OF HUSBAND OR WIFE John C. Cole

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS John C. Cole 6604 Etzel Ave.	
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) anacem - DUE TO (c) Cirrhosis of liver		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION 2/16/55	19b. MAJOR FINDINGS OF OPERATION Cirrhosis of Liver. 5810	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)

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?
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22. I hereby certify that I attended the deceased from **2/7/55, 10** to **7/21**, 19**55**, that I last saw the deceased alive on **2/20**, 19**55**, and that death occurred at **12:30** Am., from the causes and on the date stated above.

23a. SIGNATURE James Clancy	(Degree or title)	23b. ADDRESS University Club Bldg	23c. DATE SIGNED 7/22/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE July 23 1955	24c. NAME OF CEMETERY OR CREMATORY Middlebrook Cem.	24d. LOCATION (City, town, or county) (State) Middlebrook Mo.

DATE REC'D BY LOCAL REG. JUL 22 1955	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCollier Mortuary 10123 St. Chas. Rd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 24 1967

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 *Sheldon Collier*

Licensed Embalmer No. *338*

P. O. Address *10123 St 4*

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.