

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-037686

STATE FILE NUMBER

FILED NOV 10 1958

Registration District No.

318

Primary Registration District No.

1003

Registration No. 10221

300 0
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 0376 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL		Length of stay in lb	d. STREET ADDRESS (If outside, give location) 3/ 830 Prospect Avenue. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First UBA Middle R. Last COBLE			4. DATE OF DEATH Month OCTOBER Day 25, Year 1958
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1906
9. AGE (In years last birthday) 52		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Manager	11. BIRTHPLACE (City and state or country) Walnut Grove, Missouri.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Grocer	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME James Coble		13b. MOTHER'S MAIDEN NAME Lula McKinney	14. NAME OF HUSBAND OR WIFE Rachel Coble
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO Nil		16. SOCIAL SECURITY NO. 497-12-6468	17. INFORMANT Address Rachel Coble, 830 Prospect Avenue.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INSUFFICIENCY Springfield, Missouri. DUE TO (b) RHEUMATIC HEART DISEASE WITH AORTIC STENOSIS DUE TO (c) SUSPECTED PULMONARY EMBOLI PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 41X			INTERVAL BETWEEN ONSET AND DEATH 3 YEARS MANY YEARS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from OCT. 18, 1958 to OCT. 25, 1958 and last saw her/him alive on OCT. 25, 1958 Death occurred at 2:05 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. J. Vermillion, M.D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 10/25/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-25-58	23c. NAME OF CEMETERY OR CREMATORY Local	23d. LOCATION (City, town, or country) (State) Springfield, Missouri.
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.,		25. DATE RECD. BY LOCAL REG. OCT 25 '58	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

NOV 10 1958

MS

JUN 19 1959

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 Robert M. Murray

Licensed Embalmer No. 3749

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