

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017321

STATE FILE NUMBER

FILED JUN 8 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 523

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Willow Springs</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If not in hospital, give location) HOSPITAL OR INSTITUTION <u>Ozark Osteopathic</u>		Length of stay in lb 046 & 0	d. STREET ADDRESS (If outside, give location) <u>603 Harris</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>Steven</u> Last <u>Cottrell</u>			4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-16-1877</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Osteopathic Physician</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Monroe, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>Albert Cottrell</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Kirkpatrick</u>		14. NAME OF HUSBAND OR WIFE <u>Emma Cottrell</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>488-44-1262</u>	17. INFORMANT Address <u>Mrs J.B. Cottrell</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3:57 AM</u> <u>5/30/59</u> <u>1:11 AM</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral artery thrombosis</u>		
	DUE TO (c) <u>Cerebral arteriosclerosis</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>332X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 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 <u>Springfield, Mo.</u>	COUNTY <u>Howell</u>	STATE <u>Mo.</u>
21. I attended the deceased from <u>5/30/59</u> to <u>5/30/59</u> and last saw her/him alive on <u>5/30/59</u> Death occurred at <u>5/30/59 3:57 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>Deland E. Wetzel, D.O.</u>		22b. ADDRESS <u>Springfield, Mo.</u>		22c. DATE SIGNED <u>5/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 30 - 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Willow Springs Mo</u>	
24. FUNERAL DIRECTOR <u>Norman Schmitt</u>		ADDRESS <u>Springfield Mo</u>	25. DATE RECD. BY LOCAL REG. <u>6-1-59</u>	26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u>

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. MEDICAL CERTIFICATION. DELAND E. WETZEL, D.O.

JUN 1 0 1956

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 *L. Paulin Cornman*

Licensed Embalmer No. *3177*
P. O. Address *Strungfield*

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.