

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-018388  
STATE FILE NUMBER

FILED JUN 10 1959 Registration District No. 195 Primary Registration District No. Registrar's No. 48-59

300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>McDonald</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>McDonald</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Elk River Township</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Anderson</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hospital on 71 hwy.</b>		Length of stay in 1b <b>06 0 0</b>	d. STREET ADDRESS (If outside, give location) <b>Route # 2</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charlie Roswell Cordell</b>			4. DATE OF DEATH Month Day Year <b>May 29, 1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1896</b>
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months Days <b>1 21</b>	IF UNDER 24 HRS. Hours Min. <b>1 21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman Valve Mfg.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	11. BIRTHPLACE (City and state or country) <b>Athelston, Iowa</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>John Cordell</b>	
13b. MOTHER'S MAIDEN NAME <b>May Finch</b>		14. NAME OF HUSBAND OR WIFE <b>Elsie Marie Winter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>482-05-3963</b>	17. INFORMANT Address <b>Mrs. LaVerne Severs Anderson, Mo</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>4200</b>
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 <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 <b>5-28-59</b> to <b>5-29-59</b> and last saw him alive on <b>5-29-59</b> Death occurred at <b>2:45 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>J. J. Payne M.D.</b>		22b. ADDRESS <b>Noel, Mo.</b>	22c. DATE SIGNED <b>5/31/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6/1/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anderson Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Anderson, Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Rapp Funeral Home Anderson, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-1-59</b>	26. REGISTRAR'S SIGNATURE <b>Mary A. Bradley</b>

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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 Carl P. Papp .....

Licensed Embalmer No. 3458 .....  
P. O. Address Anderson, 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.