

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033564

LED VS SEP 13 1960

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 170

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Vernon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u> Length of stay in 1b <u>3 mo.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>402 No. Cedar St Jones Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lawrence</u> c. CITY OR TOWN <u>Mt. Vernon</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <u>George</u> Middle <u>David</u> Last <u>Cole</u>			<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>25</u> Year <u>1960</u>					
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>Wh</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-24-1878</u>	<b>9. AGE (last birthday)</b> <u>82</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Trucking</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Coffeyville, Kansas</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u>		
<b>13a. FATHER'S NAME</b> <u>Unknown</u>			<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			<b>14. NAME OF HUSBAND OR WIFE</b> <u>Martha Ellen</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs. Wilma Phillips, Chicago, Illinois</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, recurrent</u> DUE TO (b) <u>Arteriosclerosis and hypertension</u> DUE TO (c) <u>Had prior cerebral hemorrhage 3 weeks ago</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>  <u>Unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE		
<b>21. I attended the deceased from</b> <u>August 13, 1960</u> <b>to</b> <u>Aug. 25, 1960</u> <b>and last saw</b> <sup>xx</sup> <u>him</u> <b>alive on</b> <u>Aug. 25, 1960</u> <b>Death occurred at</b> <u>Nevada, Mo.</u> <u>4:40</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> (Degree or title) <u>Rolla B. May MD</u>				<b>22b. ADDRESS</b> <u>Moore Bldg., Nevada, Missouri</u>			<b>22c. DATE SIGNED</b> <u>8/30/1960</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>August 27, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Halltown Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Halltown Missouri</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Ferry Funeral Home Nevada, Missouri</u>				<b>25. DATE RECD. BY LOCAL REG.</b> <u>9-6-1960</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Arnold E. Jerry</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *L. Douglas Perry*

Licensed Embalmer No. 4960

P. O. Address Nevada

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.