WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Chariton

Township: Cockrell
or
Village:
or
City: (NO. St.; Ward)

Registration District No. 960 — File No. 9559

Primary Registration District No. 5247 — Registered No. 6

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME: Carl Casler Cook

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male — COLOR OR RACE: White — SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

DATE OF BIRTH: August 2nd (Month) (Day), 1894 (Year)

AGE: 21 yrs. 7 mos. 19 ds. — If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer — 56 E
(b) General nature of industry, business, or establishment in which employed (or employer): Farm work — 92 A, 95 D

BIRTHPLACE (City or town, State or foreign country): Chariton Co. Mo.

PARENTS
NAME OF FATHER: Josiah Andrew Cook
BIRTHPLACE OF FATHER (City or town, State or foreign country): Chariton Co.
MAIDEN NAME OF MOTHER: Ellar Viola McCune
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Chariton Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Andrew Cook

(ADDRESS): Musselfork Mo.

Filed Mch 21, 1916. Chas. A. Clarkson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH 4

DATE OF DEATH: March (Month) 21st (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from December 29 1914, to March 20, 1916, that I last saw him alive on March 20th, 1916, and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Bronchitis with mitral insufficiency and Enlargement of the heart result of Rheumatism

(Duration) 7 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) ___

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Henry Gray M. D.

Mar. 21st 1916 (Address) Prairie Hill Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: Beulah Cemetery — DATE OF BURIAL: Mch 22, 1916

UNDERTAKER: J C Rucker — ADDRESS: Keytesville Mo.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191....., that I last saw h.....alive on ....., 191....., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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