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 Buchanan

Township Agency or Village ____ or City ____ (NO. ____ St.: ____ Ward)

Registration District No. 80 File No. 14193

Primary Registration District No. 5117 Registered No. 12

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

FULL NAME Vernon Alexander Cooke

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: ____ (Month) ____ (Day), 1895 (Year)

AGE: 26 yrs. 0 mos. 1 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): ____

BIRTHPLACE (City or town, State or foreign country): Buchanan

PARENTS
NAME OF FATHER: George Cooke
BIRTHPLACE OF FATHER (City or town, State or foreign country): Kansas
MAIDEN NAME OF MOTHER: Bertha Haffner
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Missouri

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bertha Cooke

(ADDRESS) Agency Mo

Filed 6/28/21, 191__, R F Dowell REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: June (Month) 27 (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from Feb. 26, 1920, to June 27, 1921, that I last saw him alive on June 27, 1921, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23 A
30 9
31

(Duration) 2 yrs. 0 mos. 0 ds.

Contributory (SECONDARY) Tuberculosis of Kidney

8 (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Dr. S. E. Meluney M. D.

June 28 1921 (Address) Agency 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? In France

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Agency Mo

DATE OF BURIAL: June 29 1921

UNDERTAKER: H A Sullen

ADDRESS: Gower 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

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.