

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

Do not use this space.

5971

1. PLACE OF DEATH

County Louisiana Registration District No. 248 File No.
 Township Liberty Primary Registration District No. 5-844 Registered No. 3
 City (No.) St. Ward)

2. FULL NAME

Barbara C. Cook

(a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>S.M. Cook</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Oct. 12-1858</u>		
7. AGE	YEARS <u>70</u>	MONTHS <u>4</u>
	DAYS <u>11</u>	IF LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Housewife</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Housework</u>		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) Ohio
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Adam Frossinger</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>Wood Grove</u>
	12. MAIDEN NAME OF MOTHER <u>Lucina Wiser</u>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) <u>Wood Grove</u>

14. INFORMANT S.M. Cook
 (Address) Altamont Missouri

15. FILED W.S. Campbell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 23 1929

17. I HEREBY CERTIFY, That I ~~attended~~ attended from 19..... to 19.....
 that I last saw her alive on Feb. 23-1929 and that death occurred, on the date stated above, at 10-508

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia
R.H.
107R (duration) X yrs. 10 da.

CONTRIBUTORY (SECONDARY)
Paralysis (duration) 2 yrs. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) H. D. Hope Crowner
7/24, 1929 (Address) Hallatin, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Aun. - Altamont Mo DATE OF BURIAL 2-28-29

20. UNDERTAKER H. D. Hope ADDRESS Hallatin

N. H. ... very item of information, such as above, should be secured. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. MAR 21 1929

CAUSE OF DEATH in "let us see what that may be" made "Every item of
Exact statement of OCCUPATION is very

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Daniess Registration District No. 248 File No. _____
 Township Liberty Primary Registration District No. 5344 Registered No. 3
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Barbara E. Cook

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED _____, 19 _____ W. S. Lem... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) FEB 23 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19 _____ to _____, 19 _____ that I last saw him _____, 19 _____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Alber Paralysis
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY Paralysis
 (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

REGISTRATION DISTRICT NO. 248 TOWNSHIP LIBERTY COUNTY DANIESS STATE MISSOURI
 Every item of information should be correctly supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
 DECEASED SHOULD BE CAREFULLY IDENTIFIED BY NAME AND ADDRESS.
 REGISTRATION DISTRICT NO. 248 TOWNSHIP LIBERTY COUNTY DANIESS STATE MISSOURI
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SUPPLEMENTARY

S-5-971