

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

Do not use this space.

1304

1. PLACE OF DEATH

County Jackson
Township Prairie
City (No.) St. Ward)

Registration District No. 4000
Primary Registration District No. 5550

File No.
Registered No. 13

2. FULL NAME Low Cooksey

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-23-1853

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>76</u>	<u>10</u>	<u>22</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

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

10. NAME OF FATHER X

11. BIRTHPLACE OF FATHER (CITY OR TOWN) X
(STATE OR COUNTRY) X

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) X
(STATE OR COUNTRY) X

14. INFORMANT J. W. Hosteller
(Address) County Home Jackson

15. FILED 1-16-30 M. S. James REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15-30

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 15, 1930 that I last saw h. e. alive on Jan 13, 1930 and that death occurred, on the date stated above, at 1 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
82A
1530
(duration) yrs. mos. 45 ds.

CONTRIBUTORY Secondary
(SECONDARY) (duration) yrs. mos. 30 ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS clinical
(Signed) J. W. Green M. D.
1/15, 1930 (Address) Independence 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 Buckner Mo. DATE OF BURIAL Jan 16 30

20. UNDERTAKER V. M. Reppert ADDRESS Buckner Mo

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.

FEB 18 1930

