

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

Do not use this space.

31464

1. PLACE OF DEATH

County _____
Towship _____
City St. Louis

Registration District No. 791
1003
Primary Registration District No. _____

File No. _____
Registered No. 9072
St. _____ Ward _____

2. FULL NAME

Margaret Larkin Cook
(a) Residence. No. 114 Lewis Pl. St. 14 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 13 1861

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
68 10 5

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

9. BIRTHPLACE (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER James Ross Larkin
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Belvoir
(STATE OR COUNTRY) _____
12. MAIDEN NAME OF MOTHER Mary C. Chambers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
(STATE OR COUNTRY) Mo.

14. INFORMANT John R. Cook
(Address) 114 Lewis Pl.

15. SEP 19 1930 FILED _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/18/30

17. I HEREBY CERTIFY, That I attended deceased from _____ 1930 to _____ 1930 that I last saw him alive on Sept 15, 1930, and that death occurred, on the date stated above, at 2:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
82A
97

(duration) yrs. mos. ds. 6
CONTRIBUTORY Arterio-Sclerosis
(SECONDARY)

(duration) yrs. mos. ds. 6
18. WHERE WAS DISEASE CONTRACTED? At home

IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH, _____ DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) C. T. Breda, M. D.
9/19/30 (Address) Union Club Bldg

*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 Cabary DATE OF BURIAL Sept 20 1930

20. UNDERTAKER Culpen-Kelly ADDRESS 4524 Easton

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

K. 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.

