

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

Do not use this space.

File No. **22408**  
Registered No. **XX**  
St. \_\_\_\_\_ Ward)

1. PLACE OF DEATH *Salem*  
County.....*Salem* Registration District No. *266*  
Township.....*Salem* Primary Registration District No. *R 63*  
City.....*Salem, Mo.* (In \_\_\_\_\_ St. \_\_\_\_\_ Ward)  
2. FULL NAME *Prof. John W. 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 *M.* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*  
6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
*75 9 27*  
8. OCCUPATION OF DECEASED *School Teacher*  
(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) *Fanshawe*  
(STATE OR COUNTRY) *Ohio*  
10. NAME OF FATHER *Jas. C. Cook*  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) *Cincinnati*  
(STATE OR COUNTRY) *Ohio*  
12. MAIDEN NAME OF MOTHER *Sarah J. Howell*  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *Cincinnati*  
(STATE OR COUNTRY) *Ohio*

14. INFORMANT *John W. Cook*  
(Address) *Salem, Mo.*  
15. FILED *7/28 1932* *J. C. Ruder*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 28, 1932*  
17. I HEREBY CERTIFY, That I attended deceased from *July 28, 1932* to *July 28, 1932*  
that I last saw him alive on *July 28, 1932* and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*enteritis*  
*digestive distur-*  
*banes*  
(duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) *banes* (duration) yrs. mos. ds.

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 *Verbal Physical*  
*H. C. Ruder* M. D.  
\*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 *New Harmony* DATE OF BURIAL *7/29 1932*  
20. UNDERTAKER *Carl H. Spencer* ADDRESS *Salem, Mo.*

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.

AUG 3 1932



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Louis  
Township Sales  
City Sales (No. ....)

Registration District No. 266  
Primary Registration District No. 4164

File No. ....  
Registered No. 44  
St. .... Ward)

**2. FULL NAME**

(a) Residence, No. .... 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 M 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) Oct 1, 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
75 9 27

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED 7/28 19 33 H. E. Rudd Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28, 1932

22. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19.....

I last saw him ..... alive on ..... 19..... Death is said

to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

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

(Address) .....

**SUPPLEMENTARY**

ed EXACTLY. PHYSICIANS should be carefully supplied. AGE should be properly classified. in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. N. B. CAU

5-22409