

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

Do not use this space.

1. PLACE OF DEATH

County DEKALB
Township 2
City (No. _____) _____

Registration District No. 258
Primary Registration District No. 53604

File No. 16243
Registered No. _____
St. _____ Ward _____

2. FULL NAME HANNAH 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 FEMALE
4. COLOR OR RACE WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) WIDOWED

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) OCT 2 - 1847

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
87 4 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work RETIRED HOUSEKEEPER
(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) MO

10. NAME OF FATHER JAMES HICKLIN

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) NOT KNOWN

12. MAIDEN NAME OF MOTHER ELVIRA SLADE

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) NOT KNOWN

14. INFORMANT LAURA ROBINSON
(Address) CLARKSDALE, MO

15. FILED _____ 19 _____ REGISTRAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 19 1934

17. I HEREBY CERTIFY, That I attended deceased from 4/10/34 1934 to 5/10/34 1934 that I last saw h.e.r. alive on 5/10/34 1934, and that death occurred, on the date stated above, at 3-30 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility

162

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) 162 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRAINTED

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) [Signature] M.D.

, 19 (Address) Clarksdale 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

BETHEL CEMETERY

20. UNDERTAKER

E. M. Davis - Clarksdale, Mo.

DATE OF BURIAL

5/21 1934

ADDRESS

JUL 20 1934
 N. E. ...
 CAUSE OF DEATH ...
 Exact statement of OCCUPATION ...
 AGE should be stated EXACTLY. ...
 Do not use this space.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Alexandria Registration District No. 258 File No.
 Township Washington Primary Registration District No. 5360a Registered No.
 City (No.) St. Ward)

2. FULL NAME

Hannah 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 w (write the word)

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.
87 4 5

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...

19. UNDERTAKER C. M. Davis Clarkdale Mo. (ADDRESS)

20. FILED 5-19 1938 Mrs. C. A. Davis Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 19 1934

22. I HEREBY CERTIFY, That I attended deceased from

to 19...

I last saw h..... 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:

Date of onset

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

N. B. - Item of information 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

S-16243