

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

22156
 Do not use this space.

REC'D JUL 11 1939
 1. PLACE OF DEATH
 (a) County GREENE Registration District No. 315
 (b) Township SPRINGFIELD Primary Registration District No. 2001
 (c) City SPRINGFIELD (d) Street No. 1125 NATIONAL BOULEVARD
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME GRACE COOK
 (a) Residence, No. FAIR GROVE MO. # 2
 (Usual place of abode, if no street address, write county or city) (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
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 10 - 1888
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
70 10 14
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House work
 9. Industry or business in which work was done, as saw mill, bank, etc. In own home
 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) Iowa
 FATHER 13. NAME Abram Cook
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mass.
 MOTHER 15. MAIDEN NAME Eleanor Westerman
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maine
 17. INFORMANT (ADDRESS) G. P. Cook Springfield, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Azlewood DATE June 26, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Klingner Springfield, Mo.
 20. FILE June 26, 1939 Chas. A. George, M.D. 296
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24, 1939
 22. I HEREBY CERTIFY that I attended deceased from May 5, 1939 to June 21, 1939
 I last saw h. alive on June 21, 1939 Death is said to have occurred on the date stated above, at 8:45 A.M.
 The principal cause of death and related causes of importance were as follows:
Carcinoma pylorus of stomach about 9 years
Fracture of hip (neck of femur)
 Other contributory causes of importance:
none
 Name of operation none Date of none
 What test confirmed barium rays Was there an autopsy? no
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no, 1939
 Where did injury occur? no (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury no
 Nature of injury no
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify no
 (Signed) Daniel L. Yancey M. D.
 (Address) Springfield, Mo.

WHILE PRINTING, WITH GRAYING 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

1944
8/11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Wm. Ray Proctor

Licensed Embalmer No.

4071

P. O. Address

Princeton, N.J.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF ANATOMY

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

22156
Do not use this space.

1. PLACE OF DEATH

(a) County Greene Registration District No. 318
(b) Township _____ Primary Registration District No. 2001 Registered No. 5-18
(c) City Springfield (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Grace Court

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S (Use 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.
70 10 14

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

9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED July 31 1939 Chas A. George Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-24, 1939

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:

Cardiogenic Pylorus
Stomach
186 W
15
Date of onset 3/5

Other contributory causes of importance:
Fracture of hip neck of femur
3/4/39

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. accident Date of injury 7/2, 1939

Where did injury occur at home (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury fall in house

Nature of injury fracture of hip neck of femur

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

If so, specify _____

(Signed) Daniel H. Barney, M. D. (Address) Springfield

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
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.

