

REC'D SEP 15 1939

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

30363  
Do not use this space.

101 of 9 Shannon 2

1. PLACE OF DEATH  
(a) County Franklin Registration District No. 1077  
(b) Township Paris Twp. Primary Registration District No. 61284  
(c) City Clatside Mo (d) Street No. \_\_\_\_\_ (If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(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 Barney R. Cooley  
(a) Residence, No. 400 Clatside Mo St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male  
4. COLOR OF RACE White  
5. (SINGLE, MARRIED, WIDOWED, OR DIVORCED) (write the word) Married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 3 - 1866  
7. AGE YEARS 71 MONTHS 9 DAYS \_\_\_\_\_ If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
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) Missouri  
13. NAME James Cooley  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Vergennes  
15. MAIDEN NAME Elizabeth Hart  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
17. INFORMANT (ADDRESS) Mrs. Mae Cooley Clatside Mo  
18. BURIAL, CREMATION, OR REMOVAL Buried DATE Aug 4 3  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. H. Mean Clatside Mo  
20. FILED 9-2 1939 Franklin Mo Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 2, 1939  
22. I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_  
I last saw him alive on Aug 29, 1939. 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:  
Apoplexy  
High Blood pressure  
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 High Blood Pressure  
(Signed) J. B. McDaniel, M. D.  
(Address) Clatside 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.

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,

*Aug 3 3*

or by

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 939 199

Date Filed 9/13/39

Signed

*John J. Arman*

Licensed Embalmer No. 2516

P. O. Address

*MT View Cm*

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.