

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.

Registration District No. 717

Primary Registration District No. 5946

Registrar's No.

1. PLACE OF DEATH:

(a) County Putman
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
(Specify whether
In this community 13 years
years, months or days)

3. (a) PRINT FULL NAME Lina Cooley
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ervin Cooley
6. (c) Age of husband or wife if alive 69 years
7. Birth date of deceased April 4 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 22 hr. min.

9. Birthplace Marysville Ia.
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER
12. Name William Hickman
13. Birthplace Lucerne Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Rebecca Tucker
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Edith Smith
(b) Address Lucerne, Mo.

17. (a) Burial (b) Date thereof 4-28-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lucerne, Mo.

18. (a) Signature of funeral director Martin Funeral Home
(b) Address Lucerne-Princeton, Mo.

19. (a) 11/27/40 (b) E. Studabaker
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Putman
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. S. of Lucerne, Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 26th
year 1940 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from April 16th
1940 to April 26th, 1940
that I last saw her alive on April 26th, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy
Due to _____
Due to 82W

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Y While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature G. A. Dale (M., D. or other)
Address Newtown, Mo. Date signed Apr. 26 1940

RECEIVED

District Health Officer No. 10

District F. No. Number 5-40-969

Date Filed MAY 9 1940

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 H. Ivan Martin

Licensed Embalmer No. 3760

P. O. Address Princeton, Mo.

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.