

Registration District No. 714

Primary Registration District No. 5944

Registrar's No. 13

1. PLACE OF DEATH
(a) County Pulaski
(b) City or town Evening Shade
(c) Name of hospital or institution:
Rural
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pulaski
(c) City or town Evening Shade
(d) Street No. Rural
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Margie Mahaley Cook
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
(b) Name of husband or wife Deceased (c) Age of husband or wife if alive _____ years
7. Birth date of deceased February 19, 1869

8. AGE: Years 71 Months 5 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Osage County, Missouri

10. Usual occupation Housewife

11. Industry or business Robert Woody

12. Name Unknown

13. Birthplace _____

14. Maiden name Sallie Ann

15. Birthplace Unknown

16. (a) Informant Lea Cook

(b) Address Evening Shade

17. (a) _____ (b) Date thereof 7/22/40

(c) Place: burial or cremation Macedonia

18. (a) Signature of funeral director [Signature]

(b) Address Richland, Missouri

19. (a) 8-1-40 (b) [Signature]

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 7 day 21 year 1940 hour 7:05 minute 05 M.

21. I hereby certify that I attended the deceased from Feb. 7-1939 to 2-7-39 1940 and that death occurred on the date and hour stated above.

that I last saw her alive on 7-19- 1940
Immediate cause of death acidosis + acute toxemia, malnutrition

Due to Carcinoma of lower esophagus + cardiac opening of stomach

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

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? _____

642 (Specify type of place) _____
While at work? _____ (e) Means of injury _____

23. Signature [Signature] (M.D. or other) D.O.
Address Reba, Mo. Date signed 7-24-40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

35

46

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.

Not Embalmed

Signed *R.B. Inger*

Licensed Embalmer No. 3198

P. O. Address Richland 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26046**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **714**

Primary Registration District No. **5944**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Pulaski**
(b) City or town **Ponchartraine**
(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 _____
In this community _____ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Margie Mahaley Cook**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **71** Months **5** Days **2** If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

20. DATE OF DEATH Month **July** day **21** year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **and acute toxic malnutrition**

Due to **Carcinoma of lower Esophagus + Cardiac opening of stomach**

(Other conditions (Include pregnancy within 3 months of death) **Chronic Gastritis + Esophagus**)

Major findings: _____ Of operations _____

Of autopsy **4/2**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **J. Skilton** (or other) **DO**

Address **melod no** Date signed **9-16-40**

SUPPLEMENTAL

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

MOTHER, FATHER

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

