

Registration District No. 896 Primary Registration District No. 6200

1. PLACE OF DEATH:  
(a) County Webster  
(b) City or town Rural-High Prairie township  
(c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
In this community life (Specify whether years, months or days) life

3. (a) PRINT FULL NAME Sherman Jackson Cook  
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased October 29 - 1940  
(Month) (Day) (Year)

8. AGE: Years X Months X Days 10 If less than one day X hr. X min.

9. Birthplace Webster Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Home

MOTHER, FATHERS  
12. Name Jackson Cook  
13. Birthplace Webster Co., Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Melissa Hayes  
15. Birthplace Webster Co., Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Sherman Cook  
(b) Address Marshfield, Mo.

17. (a) Burial (b) Date thereof Nov. 9-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation liberty

18. (a) Signature of funeral director Sherman Cook  
(b) Address Marshfield, Mo. (acting)

19. (a) Dec 23-49 (b) Elcie J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Webster  
(c) City or town Rural-High Prairie township  
(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.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov. day 8  
year 1940 hour 2 minute A. M.  
21. I hereby certify that I attended the deceased from Nov  
, 1940, to \_\_\_\_\_, 1940;  
that I last saw her alive on Nov 2, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death night labor  
Due to pernicious fever  
Due to \_\_\_\_\_  
Other conditions 105  
(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?  
at work (Specify type of place) (a) Means of injury \_\_\_\_\_  
23. Signature W.F. Behlisch (M. D. or other) \_\_\_\_\_  
Address Springer Date signed Dec 23 1949

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

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.

RECEIVED

District Health Officer No. 6

District File Number: 141-153

Date Filed: JAN-16 1947

**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**