DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1941 85

Registration District No.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 10161

Registrar's No. 363

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

1. PLACE OF DEATH:
(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST JOSEPH HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 DAYS (Specify whether years, months or days)
In this community 15 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County BUCHANAN
(c) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL")
(d) Street No. 312 E. MISSOURI AVE.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JOHN W. COOK
3. (b) If veteran, name war No
3. (c) Social Security No. NONE
4. Sex MALE
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Florence Cook
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Sept. 27, 1876 (Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 2 If less than one day hr. min.

9. Birthplace Paris, Ill. (City, town, or county) (State or foreign country)
10. Usual occupation Contractor
11. Industry or business
MOTHER FATHER
12. Name Daniel Cook
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Leolenia Brown
15. Birthplace Unknown (City, town, or country) (State or foreign country)
16. (a) Informant Mrs John Cook
(b) Address 312 East Mo Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 31, 1941 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Auburn Cem
18. (a) Signature of funeral director Roy Stamey
(b) Address St. Joseph Mo.
19. (a) 3/31/41 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 29 year 1941 hour 4:45 minute A.M.
21. I hereby certify that I attended the deceased from March 10, 1941, to March 29, 1941; that I last saw him alive on March 28, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Acc. Myocardial failure

Due to

Due to

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

23. Signature [illegible] (M. D. or other) MD
Address St. Joseph Mo Date signed 3-29-41

(Licensed Embalmer's Statement on Reverse Side) KIRKPATRICK BLDG.

200 K

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 March 29, 1941, Registered Apprentice No. ....., working under my personal supervision.

Signed John H. Hurley

Licensed Embalmer No. 4050

P. O. Address St Joseph, 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, fact should be so stated above.

. No. 2
—1-4-41
5-17-39
P1 X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10161

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 363

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph Mo
(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 (Specify whether
In this community 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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John W Cook

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

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

8. AGE: Years 64 Months 6 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

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

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

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 29
year 1941 hour minute M.

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

Immediate cause of death: ac Myocardial failure

Due to: Myocarditis 93 4

Due to: Arteriosclerosis general Hypertension Angina Pectoris

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

23. Signature Oscar W N Cain (M. D. or other) MD
Address St Joseph Mo Date signed June 10 '41

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

S-10161 : 1941

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.