DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 19 1942

Registration District No. 496

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3025

24699

State File No.

Registrar's No. 97

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

1. PLACE OF DEATH:
(a) County: Linn
(b) City or town: Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 706 Lincoln
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community: 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Linn
(c) City or town: Brookfield
(If outside city or town limits, write "RURAL")
(d) Street No.: 706 Lincoln
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: MARCUS-ADELBERT-COOLEY
3. (b) If veteran, name war:
3. (c) Social Security No.: None
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Mary Lavinia Cooley
6. (c) Age of husband or wife if alive: 80 years
7. Birth date of deceased: January (Month) 12 (Day) 1851 (Year)

8. AGE: Years	Months	Days	If less than one day
91	6	4	hr. min.

9. Birthplace: Batavia (City, town, or county) Illinois (State or foreign country)
10. Usual occupation: Retired Railroad Engineer
11. Industry or business:
FATHER
12. Name: Adelbert Cooley
13. Birthplace: Vermont (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Laura Peck
15. Birthplace: Illinois (City, town, or county) (State or foreign country)
16. (a) Informant: Ella Cooley
(b) Address: Brookfield
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 18 (Month) (Day) 42 (Year)
(c) Place: burial or cremation: Rose Hill Cemetery - Brookfield
18. (a) Signature of funeral director: Hill Chapel
(b) Address: Brookfield
19. (a) 7-18-1942 (Date received local registrar) (b) H W Coman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16 year 1942 hour 9 minute P.M.
21. I hereby certify that I attended the deceased from July 11, 1942, to July 16, 1942, that I last saw him alive on July 16, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary occlusion	5 mins
Due to fractured hip	5 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:
Of autopsy:

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): 058
(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: 2
23. Signature: W. B. Simpson (M. D. or other) DO
Address: Brookfield Date signed: 7-17-42

456

(Licensed Embalmer's Statement on Reverse Side)

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 J. H. Blacklock, Registered Apprentice No. ..... working under my personal supervision.

Signed J. H. Blacklock

Licensed Embalmer No. 2246

P. O. Address Brookfield Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

S. No. 2B
M-8-21-41
T X25228

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24699

Registration District No. 496 Primary Registration District No. 3025 Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Linn

(b) City or town: Brookfield (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 years, months or days)

In this community: 50 yrs.

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

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: Jan (Month) 12 (Day) 1851 (Year)

8. AGE: Years 91 Months 6 Days 4 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (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 July 6 year 1942 hour 9 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.

	Duration
Immediate cause of death: Coronary occlusion	5 min
Due to: fractured hip due to fall	5 days
Due to: was run over by a bicycle	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: none 18a

Of autopsy: none 18

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: W. B. Simpson D.O. (M.D. or Coroner)

Address: Brookfield Mo. Date signed 7/7/42

SUPPLEMENTARY