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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32225

State File No.

FILED SEP 17 1943
Registration District No. 268

Primary Registration District No. 5906

Registrar's No.

1. PLACE OF DEATH:

(a) County Pemiscot
(b) City or town 1/4 MILE EAST OF PEACH ORCHARD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ABOVE / 1/2 MILE River Junc
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution NONE
(Specify whether
In this community ALL OF LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County PEMISCOT
(c) City or town RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. 1/4 MILE EAST OF PEACH ORCHARD
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME AUBREY TAYLOR COOK

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

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced INFANT
6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive NONE years
7. Birth date of deceased OCTOBER 17 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 10 10 hr. min.

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

10. Usual occupation INFANT.

11. Industry or business NONE.

MOTHER FATHER { 12. Name WILLIAM T. COOK
13. Birthplace FORREST CITY ARK.
(City, town, or county) (State or foreign country)
14. Maiden name BESSIE THOMASON
15. Birthplace CHERRY VALLEY ARK.
(City, town, or county) (State or foreign country)

16. (a) Informant BESSIE COOK

(b) Address PEACH ORCHARD, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-43
(Month) (Day) (Year)

(c) Place: burial or cremation MALDEN, MO.

18. (a) Signature of funeral director Way Thurnal Stone

(b) Address Malden Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 27th,
year 1943 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from Aug 12
19 43 to Aug 27 19 43
that I last saw him alive on Aug 12
and that death occurred on the day and hour stated above.

Immediate cause of death Cholera
Due to Cholera

Due to Cholera

Other conditions (Include pregnancy within 3 months of death) 119a

Major findings: Of operations 119a
Of autopsy no

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) 0

(b) Date of occurrence 0

(c) Where did injury occur? 0 (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 kind of place) Means of injury 0

23. Signature B. J. O'Leary (M. D. or other)

Address Indian Date signed Aug 27/43

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

SEP. 17 1943

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.....

J. D. Schuman

Licensed Embalmer No. *4086*

P. O. Address *Malden, Mass.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *oct*

Registration District No. *268*

Primary Registration District No. *5906*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Pemissiat*
(b) City or town *Little River Sup*
(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)

3. (a) PRINT FULL NAME *Aubrey Taylor 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 *s*

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

7. Birth date of deceased *oct. 17*
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *10 2 1943* (b) *J.P. Cherry*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *10* 27
year *1943* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him/her alive on _____ 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER, FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

32226