

FILED FEB 15 1944

Registration District No. 236

Primary Registration District No. 6122

Registrar's No.

1. PLACE OF DEATH

(a) County Shannon  
(b) City or town Rural, Blaine Creek Twp  
(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 1  
(Specify whether

In this community 1  
years, months or days)

3. (a) PRINT FULL NAME

Thomas O Cook

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex M 5. Color or race O 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased Feb 26 1883  
(Month) (Day) (Year)

8. AGE: Years 60 Months 11 Days 2 If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Cook Cook  
13. Birthplace unknown 9  
(City, town, or county) (State or foreign country)

14. Maiden name Brown White  
15. Birthplace Ellington Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Cook Cook  
(b) Address Midway Mo  
17. (a) Rural (b) Date thereof 2-9-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bartley Mo  
18. (a) Signature of funeral director J F Bureau  
(b) Address 704 Paul St

19. (a) 2-9-44 (b) Frank Hyde MD  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shannon  
(c) City or town Rural, Blaine Creek Twp  
(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 Feb day 8  
year 1944 hour \_\_\_\_\_ minute 5 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 Cardiovascular  
sinus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 13/a  
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? \_\_\_\_\_

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

23. Signature Frank Hyde (M. D. or other) \_\_\_\_\_

Address Quincy Mo Date signed 2-9-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File No.

244160

Date Filed

2. 17-44

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**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, fact should be so stated above.**