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K32873

FILED FEB 18 1944
818

State File No.

Registration District No.

Primary Registration District No. 1003

Registrar's No. 1323

1. PLACE OF DEATH:

(a) County.....
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3254 N. 19 ST. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. NIL
(Specify whether
In this community. 40 DAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State. MISSOURI (b) County.....
(c) City or town. ST. LOUIS 26
(If outside city or town limits, write "RURAL")
(d) Street No. 3254 N. 19 ST.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME JAMES W. COOK
3. (b) If veteran, name war. SPANISH AMER. 3. (c) Social Security No. 431-16-2838

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month FEB. day 10
year. 1944 hour. 1 minute. A M.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced. WIDOWED
6. (b) Name of husband or wife. NANCY COOK 6. (c) Age of husband or wife if alive. DEC. years
7. Birth date of deceased. FEB 16, 1874
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased Jan 30 1944 to Feb 6 1944
that I last saw him alive on Feb 6 1944
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
69 11 24 hr. min.

Immediate cause of death. Cardio-Vascular disease
Due to.....
Due to.....

9. Birthplace GREEN CO. ARKANSAS
(City, town, or county) (State or foreign country)
10. Usual occupation. TRUCK GARDNER

Other conditions Chronic Nephritis 27mo.
(Include pregnancy within 3 months of death)
Major findings:
Of operations.....
Of autopsy.....

MOTHER FATHER

11. Industry or business " "
12. Name HENRY COOK
13. Birthplace UNKNOWN ARKANSAS
(City, town, or county) (State or foreign country)
14. Maiden name KATIE BAKER
15. Birthplace UNK. ARKANSAS
(City, town, or county) (State or foreign country)

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

16. (a) Informant MRS DAYLIE WAINSCOTT
(b) Address 3254 N. 19 ST.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

17. (a) BURIAL (b) Date thereof. FEB 13 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. JONESBORO, ARK.

(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. 1

18. (a) Signature of funeral director. Cluedmeyer & Glona
(b) Address 3984 N. 20 ST.
19. (a) FEB 10 (b) J. J. Branch
(Date received from Registrar) (Registrar's signature)

23. Signature J. J. Branch (M. D. or other) MD
Address 4220 N. Bond Date signed 2-10-44

REPRODUCING BLACK INK—MAKE A PERMANENT RECORD

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 Alfred J. Godeker
Licensed Embalmer No. 2663
P. O. Address 5974 26th

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.