

FILED APR 20 1944

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15963

Primary Registration District No. C153

Registrar's No. 27-23

1. PLACE OF DEATH:

(a) County: **Stoddard**
 (b) City or town: **Rural** *Palmo Sumr*
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **X**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: **About 2 Years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME: **Samuel Monroe Cook**

(b) If veteran, name war: **X** (c) Social Security No.: **X**

4. Sex: **M** (b) Color or race: **W**
 5. (a) Single, widowed, married, divorced: **9**
 6. (b) Name of husband or wife: **X** (c) Age of husband or wife if alive: **3** years (Day) (Year) **1877**

7. Birth date of deceased: **6** (Month) **3** (Day) **1877** (Year)
 8. AGE: Years **66** Months **9** Days **3** If less than one day hr. **X** min.

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

10. Usual occupation: **Farmer**

11. Industry or business:

12. Name: **Daniel M. Cook**
 13. Birthplace: **Tenn.** (City, town, or county) (State or foreign country)
 14. Maiden name: **Susan J. Hawkins**
 15. Birthplace: **Tenn.** (City, town, or county) (State or foreign country)

16. (a) Informant: **Frank E. Cook**

(b) Address: **Canalou Mo.**

17. (a) **Burial** (b) Date thereof: **3 8 44** (Month) (Day) (Year)
 (c) Place: burial or cremation: **Moreland Ark.**

18. (a) Signature of funeral director: **H.W. Albritton**

(b) Address: **Sikeston Mo.**

19. (a) **March 20 44 M. R. Shrewer** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Stoddard**
 (c) City or town: **Rural** (If outside city or town limits, write "RURAL")
 (d) Street No.: **X** (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country: **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **6**
 year **1944** hour **11** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **2-21**
1944, to **3-7**, 19**44**
 that I last saw h. **live** alive on **3-7**, 19**44**
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Lung Cancer?**

Due to: **H 7d**

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: **J. M. Sarno M.D.** (M. D. or other)
 Address: **Moreland Ark.** Date signed: **3-8-44**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 444-649

Date Filed 4-12-44

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.....

Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed Hunter Albright

Licensed Embalmer No. 4210

P. O. Address S. Jackson

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.

FILED SEP 13 1944
Registration District No. 8

Primary Registration District No. 6153

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural Pike 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 Samuel M. Cook

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 3
(Month) (Day) (Year)

8. AGE: Years 66 Months 9 Days 3 (Unless than one day)

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

10. Usual occupation _____

11. Industry or business _____

12. Name Daniel M. Cook

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

14. Maiden name Susan Hawthorn

15. Birthplace Canalou mo
(City, town, or county) (State or foreign country)

16. (a) Informant Frank E. Cook

(b) Address Canalou mo

17. (a) Rural (b) Date thereof 3-8-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mareland Ark

18. (a) Signature of funeral director H. W. Albritton

(b) Address Pikesburg mo

19. (a) 3/20/44 (b) M. R. Johnson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Stoddard

(c) City or town Rural Pike
(If outside city or town limits, write "RURAL")

(d) Street No. X (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March
year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 2-21
1944 to 3-7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to coronary

Due to of lung

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) _____

(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 S. M. Lane (M. D. or other) M.D.
Address Mareland Date signed 3/8/44

SUPPLEMENTARY

RECEIVED

District Health Office No. 2

District File Number 94-472

Date Filed 9-11-64

15903