

FILED AUG 11 1944

Registration District No. **172**

Primary Registration District No. **4203**

Registrar's No. **287**

1. PLACE OF DEATH:

(a) County Grundy

(b) City or town Galt Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Streets not numbered /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community over 25 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Grundy

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

(d) Street No. _____ (If rural, give location) Not numbered

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

3. (a) PRINT FULL NAME MARY OIENGE COOKSEY

3. (b) If veteran, name war No

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29
year 1944 hour 10 minute P. M.

4. Sex Female

5. Color or race Wh

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

6. (b) Name of husband or wife M. J. Cooksey

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased Nov 9, 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 6-29-1944 to 6-29-1944; that I last saw her alive on 6-27-1944 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration 2 dr

8. AGE: Years 50 Months 7 Days 20
If less than one day hr. _____ min.

Due to _____

Due to _____

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

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation Housewife

Major findings: Of operations _____
Of autopsy _____

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

11. Industry or business Home

12. Name Jno Thad Stanford

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

14. Maiden name Jessamine Hodges

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

16. (a) Informant M. J. Cooksey

(b) Address Galt Mo

17. (a) Burial (b) Date thereof July 2-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galt Mo 2007 Cem.

18. (a) Signature of funeral director R. C. Brown

(b) Address Galt Mo

19. (a) 7-27-44 (b) L. S. Roberts
(Date received local registrar) (Registrar's signature)

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 J. C. Weston (M.D. or other) _____
Address Galt Mo Date signed 6-29-44

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

40000

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..... *PK Payne Jr*
Licensed Embalmer No..... *29400*
P. O. Address..... *Galt*

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.