

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 18 1945
Registration District No. 29745

Primary Registration District No. 5353

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

1. PLACE OF DEATH:

(a) County Dallas mo

(b) City or town Red Top Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson ms
(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 life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas

(c) City or town Red Top Rural?
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SARAH FRANCIS COOKSEY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race white

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 Sept 26 1866
(Month) (Day) (Year)

8. AGE: Years 78 Months 7 Days 1
If less than one day _____ hr. _____ min.

9. Birthplace Dallas Co Mo D
(City, town, or county) (State or foreign country)

10. Usual occupation housekeeper

11. Industry or business _____

MOTHER FATHER

12. Name B J Fraker

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

14. Maiden name Mattie Strickland

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

16. (a) Informant Miss Jasper Highfill

(b) Address Red Top, Mo

17. (a) Burial (b) Date thereof 3-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fraker

18. (a) Signature of funeral director R B Jones

(b) Address Buffalo Mo

19. (a) april 28-1945 13 11 (b) ma ad. Hoover
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 26
year 1945 hour 10 minute 00 A. M.

21. I hereby certify that I attended the deceased from March 14 to March 26, 1945.
that I last saw her alive on March 26, 1945,
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac hemorrhage
arterio sclerosis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy § 301

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)

(c) Means of injury _____

23. Signature P. J. Jamison (M. D. or other) M.D.

Address Buffalo Mo Date signed 4-2-45

Duration 12 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Officer No. 71

District

4-15-46
5-17-45

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 Monroe B Jones

Licensed Embalmer No. 4322

P. O. Address Buffalo, Mo.

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.