

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16776

State File No. _____

Registration District No. 101

Primary Registration District No. 5410

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Twin Bridges Richland
(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) About 10 years

3. (a) PRINT Thomas G. Cook
FULL NAME

3. (b) If veteran, _____ 3. (c) Social Security
name war. ✓ No. None

4. Sex Male 5. Color or White 6. (a) Single, widowed, married,
race White divorced married
6. (b) Name of husband or wife Betty Cook 6. (c) Age of husband or wife if
alive 75 years
7. Birth date of deceased May 29, 1879
(Month) (Day) (Year)

8. AGE: Years 66 Months 4 Days _____ If less than one day
hr. _____ min. _____

9. Birthplace Not known 9
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Charles Cook
13. Birthplace Not known 9
(City, town, or county) (State or foreign country)

14. Maiden name Not known
15. Birthplace Not known 9
(City, town, or county) (State or foreign country)

16. (a) Informant O. V. Osborn
(b) Address Silvian Springs Mo.

17. (a) Buried (b) Date thereof Jan 7, 1945
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (a) Signature of funeral director Friends

(b) Address Silvian Springs Mo.

19. (a) 5-1-1945 (b) Lula S. Spaulock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Douglas
(c) City or town Twin Bridges
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Richland Prop
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 1945 hour 8:00 minute 25 P. M.

21. I hereby certify that I attended the deceased from Jan 2, 1945 to Jan 5, 1945
that I last saw him alive on Jan 5 and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia 5 days
Duration 5 days

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

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) Means of injury _____

23. Signature J. T. Bingham (M. D. or other) d

Address West Plains, Mo. Date signed 1/5/45

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. 6,
District File Number 543-597
Date Filed MAY 15 1945

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.