

U.S. No. 2
FORM-5-43
REV. 5-17-39
1 X36871

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26374**
Registrar's No. **3447**

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **K. C.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **4 days**
(Specify whether years, months or days)

In this community **31 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Johnson** **999**

(c) City or town **Merriam** **14**
(If outside city or town limits, write "RURAL")

(d) Street No. **5619 Slator Rd.**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Bart R. Cook**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **495-09-1694**

4. Sex **Male** 5. Color or race **White**

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

6. (b) Name of husband or wife **unknown**

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

7. Birth date of deceased **Aug 24, 1872**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
72	11	25 22	hr. _____ min.

9. Birthplace **Clarinda Iowa**
(City, town, or county) (State or foreign country)

10. Usual occupation **Night Watchman**

11. Industry or business **George B. Peck Co.**

MOTHER FATHER

12. Name **Lorenzo Don Cook**

13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **"** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Veda M. Boehn**

(b) Address **5619 Slator Rd., Merriam, Ks.**

17. (a) **Burial** (b) Date thereof **Aug. 18, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Park Cem.**

18. (a) Signature of funeral director **Blackman**

(b) Address **2825 Independence Blvd.**

19. (a) **8-17-45** (b) **Geraldine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **16** 19**45** -
year _____ hour **4 11** P.M.

21. I hereby certify that I attended the deceased from **Aug 1, 1945** to **Aug 16, 1945**

that I last saw him alive on **Aug 16, 1945** and that death occurred on the date and hour stated above.

Immediate cause of death... **Coronary Occlusion s.dap**

Due to **Myocardial infarction**

Due to **Arterio Sclerosis 10 yrs**

Other conditions **old age**

Major findings: Of operations **no**

Of autopsy **yes**

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? _____

23. Signature **M. B. Caselberg M.D.**
Address **40003 Altman** Date **8/17/45**

(Licensed Embalmer's Statement on Registry Side)

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

48
3
7

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

W D Blackman

Licensed Embalmer No. 3639

P. O. Address 2825 Indep. Blvd., K. C., 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.