

FILED OCT 1 1945
Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
5240 Brookwood Avenue, /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution NO.
(Specify whether)

In this community 6 weeks
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson, 48

(c) City or town Kansas City, 3
(If outside city or town limits, write "RURAL")

(d) Street No. 5240 Brookwood Avenue, 8
(If rural, give location)

(e) Citizen of foreign country? no. (Yes or No) 0
If yes, name country X

3. (a) PRINT FULL NAME Harry W. Cooke

3. (b) If veteran, NO. Social Security # 516-18-8803
name war NO. Not unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife Mrs. Mary Cooke 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased December 8 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 9 11 hr. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 19
year 1945 hour 5:45 minute P. M.

21. I hereby certify that I attended the deceased from Aug 1
15 to 9/19/45, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinoma R+ Kidney
With Multiple General
Metastases to lungs
River etc

Due to about 6 mos.

Other conditions (Include pregnancy within 3 months of death)

Major findings: 52a

Duration about 6 mos.

PHYSICIAN 52a

Underline the cause to which death should be charged statistically.

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

10. Usual occupation Employee

11. Industry or business Sunflower Ordinance Plant

Name Albert L. Cooke

Birthplace Iowa, /
(City, town, or county) (State or foreign country)

Residence name Hallie Kirkpatrick

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

12. Informant Mrs. Mary Cooke

(b) Address 5240 Brookwood Avenue, K. C., Mo.

17. (a) removal (b) Date thereof 9-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Abilene, Kansas,

18. (a) Signature of funeral director Stine & McClure,
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 9-20-45 (b) Geraldine Holmes
(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? _____

While at work? (Specify type of place) (c) Means of injury _____

23. Signature John H Oglethorpe M.D. (Date of death) 9/20/45
Address 130 Prof Bldg Date 9/20/45

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

MONTHLY REPORT
COPIES TO BE
MAILED
9-19-45

Dr. John Ogelvie *[Signature]*

FEB 18 1946

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 *Robert H Reed*

Licensed Embalmer No. *3745*

P. O. Address *N.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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3886

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Harry W. Cooke

3. (b) If veteran, name war _____ 3. (c) Social Security No. 511-18-8803

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-20-45 (b) Sheraldine Holmes (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 19 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

1945
S-29592