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8-13
17-39
X37823

FILED OCT 11 1945

Registration District No. 22

Primary Registration District No. 4353

Registrar's No. 17

1. PLACE OF DEATH:

(a) County New Madrid

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

(c) Name of hospital or institution: Home of B.A. Cook
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 30 yr. (Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County New Madrid

(c) City or town Yidion Mo.
(If outside city or town limits, write "RURAL")

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

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

3. (a) PRINT FULL NAME JAMES ALBERT COOK

3. (b) If veteran, name war _____ 3. (c) Social Security No. 431-28-6852

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

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

7. Birth date of deceased Mar. 8 - 1886
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>8</u>	<u>12</u>	hr. <u>—</u> min. <u>—</u>

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

10. Usual occupation Barber

11. Industry or business _____

12. Name John Cook

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

14. Maiden name ek

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

16. (a) Informant Marion Cook

(b) Address Yidion Mo.

17. (a) Burial (b) Date thereof Sept 21 - 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stamfield

18. (a) Signature of funeral director Lambert J. Home

(b) Address Campbell Mo.

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 20
year 1945 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from Sept 2 - 1945 to Sept 20 - 1945
that I last saw him alive on Sept 20 / 45, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of stomach
liver

Due to _____

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations H&H

Of autopsy

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 2

23. Signature M. Allen (M. D. or other) _____

Address M. Allen Date signed Sept 29 45

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 1045-3085

Date Filed 10-5-45

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 Christina M. Landess

Licensed Embalmer No. 4227

P. O. Address Campbell, Md.

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

State File No. sect
Registrar's No. 17

Registration District No. 237

Primary Registration District No. 4353

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Hidexon city
(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

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

3. (a) PRINT FULL NAME

James A. Cook

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color of race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased mar 8

(Month)

(Day)

(Year)

8. AGE:

Years 59

Months 6

Days 24

(If less than one day _____ min.)

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Sept 21, 1945

(Date received local registrar)

(b) Mrs. Byron Sharp

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 20
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____;
that I first saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
(Immediate cause of death) _____

Duration _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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)

(b) 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 _____ (M. D. or other)

Address _____ Date signed _____

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