DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 38756

FILED DEC 12 1945

Registration District No. 840

Primary Registration District No. 4503

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Stoddard

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

(c) Name of hospital or institution: Home
(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 103

(c) City or town 1
(If outside city or town limits, write "RURAL")

(d) Street No. 6
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Brenda Kay Cook

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Fm 1

5. Color or race White

6. (a) Single, widowed, married, divorced Baby O

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

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

7. Birth date of deceased Sept (Month) 15 (Day) 1945 (Year)

8. AGE: Years | Months 1 | Days 4 | If less than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name Cecil Clyde Cook
13. Birthplace Stoddard Co. (City, town, or county) Mo. (State or foreign country)

MOTHER
14. Maiden name Bertie Agnes ~~[illegible]~~ Gann
15. Birthplace Bernie (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Cecil Clyde Cook
(b) Address Bernie Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Bernie Cemetary

18. (a) Signature of funeral director [illegible]
(b) Address Bernie Mo.

19. (a) 11-21-45 (Date received local registrar) (b) Cardie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day .....
year ..... hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from October 19 1945 Only, 19....;
that I last saw her alive on 10-19-45, 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Lobar	unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

108

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? ..... (Specify type of place)

While at work? ..... (e) Means of injury?

23. Signature F O Kelley (M. D. or other)

Address Bernie Mo Date signed 11-6-45

1133 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Office No.
District File Number 1345-3
Date Filed 12-6-4

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 Body not embalmed, Registered Apprentice No. working under my personal supervision.

Signed Robert E. Drum Funeral

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 340 Primary Registration District No. 4503 Registrar's No. 26

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bernie
(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 years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

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

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

Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Brenda F. Cook

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 15 1945
(Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 8-21-45 (Date received local registrar) (b) Cordie Miller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 9 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.

	Duration
Immediate cause of death	
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

38756