

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. **5354**

Registration District No. 149 Primary Registration District No. 1002

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: Osteopathic Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution D.O.A.  
In this community none years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cass 19  
(c) City or town Harrisonville 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Route #2 0  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James Edward Cook  
3. (b) If veteran, name war none 3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Dec. day 24  
year 1945 hour 11 minute 00A. M.

4. Sex male 5. Color or race white  
6. (a) Single (widowed, married, divorced, infant)  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: September 2 1945  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Mon. Dec. 24  
7:30 A.M. 1945 to \_\_\_\_\_ 1945  
that I last saw h. i. alive on Dec. 24 1945  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
0 3 22 hr. min.  
9. Birthplace: Los Angeles Calif /  
(City, town, or county) (State or foreign country)  
Infant

Immediate cause of death: BRONCHIO PNEUMONIA Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 107

11. Industry or business \_\_\_\_\_  
12. Name William Lloyd Cook  
13. Birthplace California Missouri /  
(City, town, or county) (State or foreign country)  
14. Maiden name Martha Jane Aldridge  
15. Birthplace East Lynn Missouri /  
(City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. William L. Cook  
(b) Address Harrisonville Missouri  
17. (a) Burial (b) Date thereof 12-27-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Mt. Washington Cem.  
Geo. C. Carson Funeral Home  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Independence Missouri  
19. (a) 12-27-45 (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) (e) Means of injury \_\_\_\_\_  
23. Signature Paul H. Stein (M. D. or other) D.O.  
Address Harrisonville, Mo. Date signed Dec. 26-45

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

100331

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**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 George C. Laram  
Licensed Embalmer No. 2249  
P. O. Address Indep. 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.**