

No. 2
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5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 24 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38073

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4755

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town KC Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: 12 hrs. 55 min.
(Specify whether
In this community 12 hrs 55 min
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Jackson
(c) City or town KC
(If outside city or town limits, write "RURAL")
(d) Street No. 4234 Holledge
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: no

3. (a) PRINT FULL NAME

Perry Cook

3. (b) If veteran, name war: no
3. (c) Social Security No. none

4. Sex Male 5. Color or race w
6. (a) Single widowed, married, divorced no

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

7. Birth date of deceased: 11-12-1947
(Month) (Day) (Year)

8. AGE: Years - Months - Days - If less than one day 12 hr. 55 min.

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

10. Usual occupation: new born

11. Industry or business: _____

12. Name: Clyde Jerome Cook

13. Birthplace: Longmont Colo
(City, town, or county) (State or foreign country)

14. Maiden name: Marjorie Frances Bush

15. Birthplace: Detroit Mich
(City, town, or county) (State or foreign country)

16. (a) Informant: mother

(b) Address: 4234 Holledge KC Mo.

17. (a) Burial (b) Date there: 11-15-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Green Lawn

18. (a) Signature of funeral director: C.H. Blackman & Son, Inc
(b) Address: 2825 Independence Blvd.

19. (a) 11-14-47 (b) Seraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 12
year 1947 hour 1 minute 45 P.M.

21. I hereby certify that I attended the deceased from 11-12, 1947, to 11-12, 1947.
that I last saw him alive on 11-12, 1947,
and that death occurred on the date and hour stated above.

Immediate cause of death: Premature infant (4 1/2 mos.)
Duration _____

Due to: Marginal placenta praevia.

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

Major findings: _____
Of operations: 1600
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? _____

While at work? _____ (Specify type of place)
(e) Means of injury: 0

23. Signature: John A. O'Brien (M. D. or other) M.D.
Address: 306 E 12 - KC Mo. Date signed: 11-12-47

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.