

FILED MAR 18 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-012891

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 391 PRIMARY REG. DIST. NO. 4505 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Bell City</u>		c. LENGTH OF STAY (in this place) <u>20yr.</u>	c. CITY OR TOWN <u>Bell City</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
		STREET ADDRESS (If rural, give location) <u>1830</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Martha</u> b. (Middle) <u>Ann</u> c. (Last) <u>Cook</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 25 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed 2</u>	8. DATE OF BIRTH <u>10-14-1881</u>
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Month <u>4</u> Day <u>11</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House hold</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			

13a. FATHER'S NAME <u>Robert Capps</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Brush</u>	14. NAME OF HUSBAND OR WIFE <u>John F. Cook</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>none</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Geo. Holder, Glen Allen, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10 Min.</u>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hemorrhage of lungs</u>		DUPLICATE OF (a) <u>Hemorrhage of lungs</u>		
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
		DUE TO (b) <u>Asthma</u>		<u>10 years</u>
		DUE TO (c)		
		II. OTHER SIGNIFICANT CONDITIONS		
		Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>2</u>

22. I hereby certify that I attended the deceased from July, 1955, to Feb 25, 1958, that I last saw the deceased alive on Feb. 24, 1958, and that death occurred at 2 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Clifford W. Rivers, D.C.3</u>	23b. ADDRESS <u>Bell City, Missouri</u>	23c. DATE SIGNED <u>3-1-58</u>
24a. BURIAL, CREMATION, OR OTHER DISPOSAL <u>Burial</u>	24b. DATE <u>2-27-58</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Faunt Hill</u>
24d. LOCATION (City, town, or county) (State) <u>Scott County, Mo</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Morgan, Adams, Mo</u>	
DATE REC'D BY LOCAL REG. <u>3/3/58</u>	LOCAL REG. SIGNATURE <u>Derrice Moore</u>	25. FUNERAL DIRECTOR'S ADDRESS

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

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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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *W^m H May*

Licensed Embalmer No... *464*

P. O. Address *Adovance,*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.