

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022787  
STATE FILE NUMBER

FILED JUL 14 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6110**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>East St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Alexian Bros.</b>		Length of stay in 1b <b>2 days</b>	d. STREET ADDRESS (If outside, give location) <b>3102 Bent Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM MCKINLEY COOK</b>			4. DATE OF DEATH Month Day Year <b>June 27, 1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1898</b>	9. AGE (In years last birthday) <b>60</b>	10. UNDER 1 YEAR Months Days Hours Min. <b>11 15</b>	11. UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician - St. Louis Flower Mill</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. David, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>James Robert Cook</b>	13b. MOTHER'S MAIDEN NAME <b>Ida May Ford</b>	14. NAME OF HUSBAND OR WIFE <b>Ada Cook</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W. W. I.</b>	16. SOCIAL SECURITY NO. <b>333-16-1553</b>	17. INFORMANT Address <b>Ada Cook - E. St. Louis, Illinois</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
Conditions, if any, which gave rise to above cause (c), stating the underlying cause last.	DUE TO (b) <b>chronic cardiac vascular disease</b>	<b>several years</b>
	DUE TO (c) <b>Severe Hypertension</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Severe Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <b>6-1-59</b> to <b>6-27-59</b> and last saw him alive on <b>6-27-59</b> Death occurred at <b>2:30 a.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Ernest S. Trevelius, M.D.</b>	22b. ADDRESS <b>157 Leroy Ferry Parkway Mo.</b>	22c. DATE SIGNED <b>6-27-59</b>
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23a. BURIAL, CREMATION, REQUIEM (Specify)	23b. DATE <b>6/29/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial Gardens - Belleville, Illinois</b>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <b>John J. [Signature]</b>	ADDRESS <b>E. St. Louis, Ill.</b>	25. DATE REC'D. BY LOCAL REG. <b>JUN 29 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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

Student .....  
Signature of Student Embalmer

Signed Joseph J. Kusaly  
Licensed Embalmer No. 7541  
P. O. Address E. H. Lane

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.