

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024179

FILED VS AUG 10 1959

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801

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in 1b 43 yrs. | c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA - Mo. Methodist Hosp. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 1804 So. 24th St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First MIDDLE Last LELA ANNA COOK | | | 4. DATE OF DEATH Month Day Year August 4 1959 | | |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-8-1899 | 9. AGE (last birthday) 59 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator | 10b. KIND OF BUSINESS OR INDUSTRY Big Smith Mfg. Co. | 11. BIRTHPLACE (City and state or country) Bedford Iowa | 12. CITIZEN OF WHAT COUNTRY U S A |
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| 13a. FATHER'S NAME James A. George | 13b. MOTHER'S MAIDEN NAME Myrtle Leonard | 14. NAME OF HUSBAND OR WIFE Elmer F. Cook |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. 493-14-5945 | 17. INFORMANT Mr. Elmer F. Cook | Address 1804 So. 24th St St. Joseph, Mo. |
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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) <u>Acute Coronary Occlusion</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Stat</u> <u>yes</u> <u>3 months</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Essen. hypertension</u> | |
| | DUE TO (c) <u>Coronary Sclerosis</u> | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 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 a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <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 <u>1950</u> to <u>May 59</u> and last saw her <u>alive</u> on <u>5-8-59</u> Death occurred at <u>8-4-59</u> <u>8</u> p. m. 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) <u>W.E. Grimes M.D.</u> | 22b. ADDRESS <u>St Joseph Mo</u> | 22c. DATE SIGNED <u>8/5/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8/7/1959 | 23c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery | 23d. LOCATION (City, town, or county) St. Joseph, Missouri |
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| FUNERAL DIRECTOR <u>Honey Funeral Home</u> ADDRESS St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG. <u>Aug. 6, 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Wm. Clark Stoddell</u> |
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DOCUMENT BY AFFIDAVIT OF M.E. Grimes M.D. 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St Joseph

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.