

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005833

FILED VS MAR 14 1960/28

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 2000 Registrar's No. 276

ENDED

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mississippi b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, Missouri		Length of stay in 1b 144 Days		c. CITY OR TOWN Natchez		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 57 Minor Street		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle XXXX Last COOKS				4. DATE OF DEATH MAR 2 1960					
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/9/24	9. AGE (last birthday) 36	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Packing House		11. BIRTHPLACE (City and state or country) Natchez, Mississippi		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME William Cooks			13b. MOTHER'S MAIDEN NAME Emma Cooks			14. NAME OF HUSBAND OR WIFE Gladys Lomax Cooks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 1914-1916		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT MCFP - Files Springfield, Missouri					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Respiratory failure							Hours		
DUE TO (b) Pneumonia							6 Days		
DUE TO (c) Pneumothorax							21 Days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Active tuberculosis							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)					
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	
21. I attended the deceased from <u>10/9/59</u> , to <u>3/2/60</u> and last saw her/him alive on <u>3/2/60</u> Death occurred at <u>10:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Clarence Kooiker, M.D. Medical Director				22b. ADDRESS MCFP - Springfield, Missouri			22c. DATE SIGNED 3/3/60		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/4/60	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) Brookhaven, Mississippi			
24. FUNERAL DIRECTOR Ayre-Goodwin Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 3-9-60		26. REGISTRAR'S SIGNATURE Effie E. Melton				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 24 1960

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 _____
Licensed Embalmer No. 4594

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.