URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 25 1960 042 Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 769

=60=025886
STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Joseph
Length of stay in 1b: 5 months 23 days
c. FULL NAME OF HOSPITAL OR INSTITUTION: St Joseph State Hospital #2
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: De Kalb
c. CITY OR TOWN: Maryville
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location)
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: SELDEN Middle: L Last: COOKE
4. DATE OF DEATH: Month 7 Day 6 Year 1960
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 1-31-1873
9. AGE (last birthday): 87
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): FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): unknown
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Samuel Cooke
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Harold L Miller Address: Maryville, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): General Arteriosclerosis
DUE TO (c): Senile Brain disease
INTERVAL BETWEEN ONSET AND DEATH

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 1-14-60, to 7-6-60 and last saw ~~her~~ him alive on 7-5-60
Death occurred at 7-6-1960 5 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Mohammad Tahir M.D
22b. ADDRESS: State Hosp #2 St Joseph Mo
22c. DATE SIGNED: 7-6-60

23a. BURIAL, CREMATION, REMOVAL (Specify): removal
23b. DATE: 7/6/1960
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) (State): Maryville Mo.
24. FUNERAL DIRECTOR: Heston-Bowman ADDRESS: St Joseph Mo
25. DATE RECD. BY LOCAL REG.: July 18, 1960
26. REGISTRAR'S SIGNATURE: Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

BY AFFIDAVIT OF — MEDICAL CERTIFICATION — DOCUMENT

M. Tahir, M.D.

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 4535

P. O. Address_____

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