

URFIELD DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040753

ENDED

Registration District No. 337 Primary Registration District No. _____ Registrar's No. 72

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Shelby</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Shelby</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Shelbyville</u>		Length of stay in 1b <u>4 Days</u>		c. CITY OR TOWN <u>Clarence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pleasant Hill Rest Home</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Cook</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>18th</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/2/1881</u>		
				9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>9</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Shelbyville Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S. #A</u>	
13a. FATHER'S NAME <u>Frank Cook</u>			13b. MOTHER'S MAIDEN NAME <u>Miranda Arnold</u>			14. NAME OF HUSBAND OR WIFE <u>Lizzie Cook</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>492-40-6669</u>		17. INFORMANT Address <u>Mrs Lizzie Cook Clarence Mo</u>			
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>Chronic Glomerulonephritis</u> <u>2 Years</u> DUE TO (b) <u>Chronic Benign Prostatitis</u> <u>3 Years</u> DUE TO (c) <u>General arteriosclerosis</u> <u>1 year</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input 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>Sept, 1946</u> to <u>Oct. 13, 1960</u> and last saw ^{her} him alive on <u>Oct 13, 1960</u> Death occurred at <u>10 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>B.L. Edrington D.O.</u>				22b. ADDRESS <u>Clarence, Mo</u>		22c. DATE SIGNED <u>10-24-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/20/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>5 Mi North Annabel Mo</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Barkelaw & Davis Shelbina Mo</u>				25. DATE RECD. BY LOCAL REG. <u>10-25-60</u>		26. REGISTRAR'S SIGNATURE <u>Ada Garcia</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Henry A. Barkley

Licensed Embalmer No. 3835

P. O. Address Shelburne

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.