

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**-62-009516**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 324 Primary Registration District No. 6093 Registrar's No. 44

**FILED MAR 5 1962**

VS 300  
Rev. 4/59

10970  
23029  
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4 1  
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133-0

DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF  
ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>32 yrs.</u>	c. CITY OR TOWN <u>Kansas City, Mo.</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Marshall State School &amp; Hosp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>118 Main St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Alvira Cook</u>			4. DATE OF DEATH Month Day Year <u>May 2-22-1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1920</u>
9. AGE (last birthday) <u>42 yrs.</u>		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) <u>Patient</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (City and state or country) <u>Richmond, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Edwin J. Cook</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Shankle</u>		14. NAME OF HUSBAND OR WIFE <u>---</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>None</u>	17. INFORMANT <u>Records of Marshall State School &amp; Hospital, Marshall, 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>Acute congestive heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mental retardation, severe</u>			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
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.)	
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>2-13-1930</u> to <u>2-22-62</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>2-22-62</u> Death occurred at <u>5:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. B. Day</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Marshall State School &amp; Hosp.</u>	22c. DATE SIGNED <u>2-22-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>3-1-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Dept. Osco Hosp</u>	23d. LOCATION (City, town, or county) (State) <u>Kirksville, Mo</u>
24. FUNERAL DIRECTOR <u>JACK W. RESER</u> ADDRESS <u>MARSHALL, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-1-62</u>	26. REGISTRAR'S SIGNATURE <u>Cecil A. Reed</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Jack M. Reese

Licensed Embalmer No. 4643

P. O. Address Marshall, Mo.

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.