

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space **19134**

1. PLACE OF DEATH

County Randolph Registration District No. 735 File No. _____
 Township Moberly Primary Registration District No. 3034 Registered No. 119
 City Jacksonville McDonough Hospital (Ward) _____

2. FULL NAME

Joseph Edward Cooley
 (a) Residence No. Jacksonville St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. 7 mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Widower
(Use the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7, 1851

7. AGE
 YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
79 / 3 / 9

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Joseph Cooley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Brunswick Mo

12. MAIDEN NAME OF MOTHER Elizabeth Cook

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Macon Co Mo

14. INFORMANT (Address) W J Cooley Centralia Mo

15. FILED June 7, 1929 Dr. Thos. S. Fleming REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 1929
17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to May 16, 1929, that I last saw him alive on May 16, 1929, and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Edema of Lungs

CONTRIBUTORY (SECONDARY) Cerebral hemorrhage
 (duration) _____ yrs. _____ mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH _____

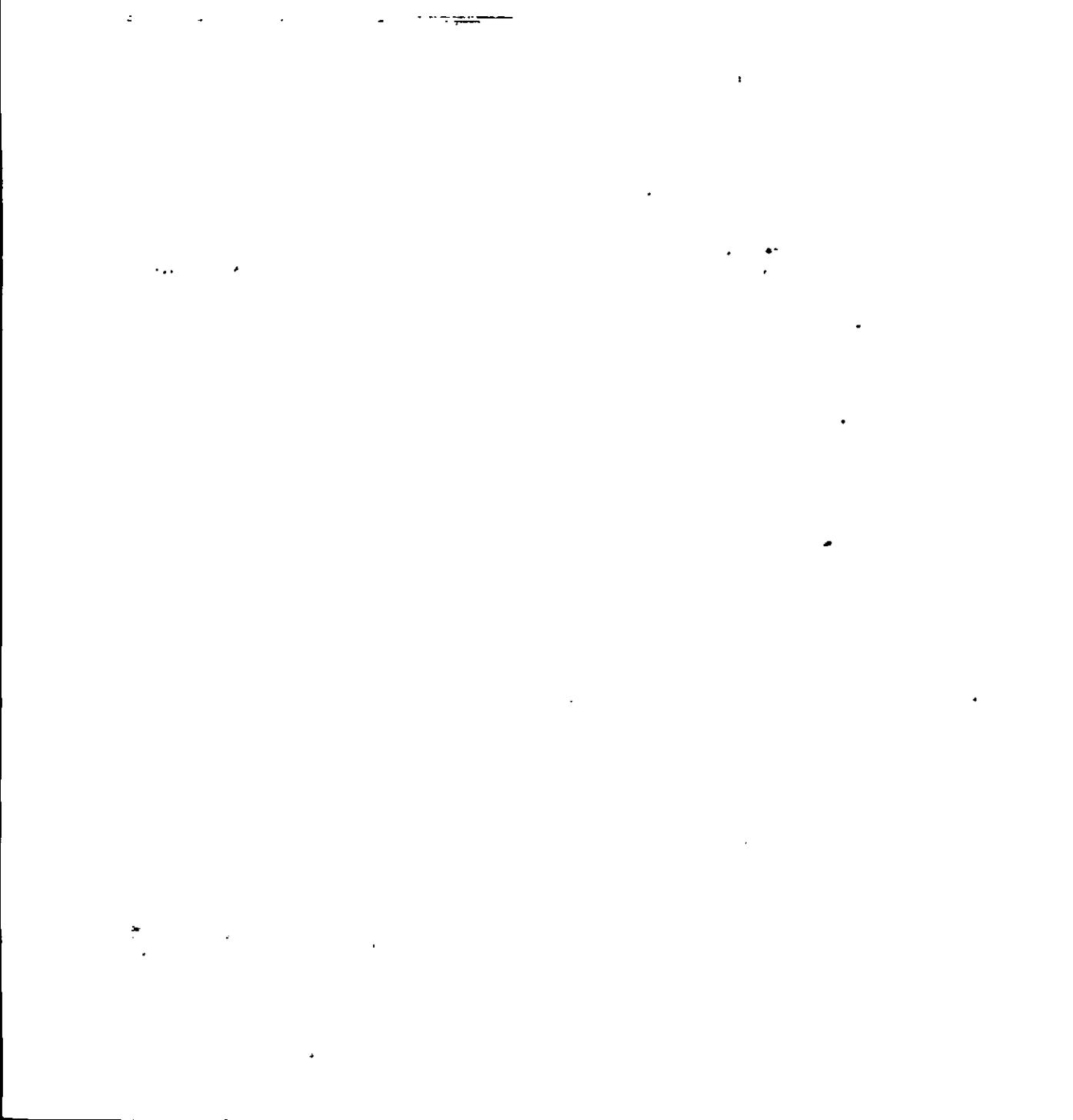
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) A. S. McCarnick, M. D.
5-18, 1929 (Address) Moberly Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Salem Cemetery **DATE OF BURIAL** 5-18 1929

20. UNDERTAKER Albert Skinner **ADDRESS** Macon Mo



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Randolph Registration District No. 735- File No. _____
 Township _____ Primary Registration District No. 3034 Registered No. 119
 City Moberly (No. _____) St. _____ (Ward)

2. FULL NAME

Joseph Edward Cooley
 (a) Residence (No. _____) St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wid
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 7-1851
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
78 3 9
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

PARENTS
 10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT (Address) _____

15. FILED 7/15, 1929 Dallas S. Flemish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 16 1929
 17. I HEREBY CERTIFY That I attended deceased from _____ 19____ to _____ 19____ that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? _____
 (Signed) _____, M. D.
 _____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

S-19134