

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D AUG 18 1939

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

26049  
Do not use this space.

1. PLACE OF DEATH

(a) County LACLEDE Registration District No. 449

(b) Township \_\_\_\_\_ Primary Registration District No. 4267 Registered No. \_\_\_\_\_

(c) City LEBANON (d) Street No. 423 SECOND ST. St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SAMANTHA L. COOK

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF M. I. COOK

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 2-1859

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	79	7	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE

9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GREEN Co. MO.

FATHER

13. NAME MINES ALEXANDER I

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TENN

MOTHER

15. MAIDEN NAME NOT KNOWN

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) NOT KNOWN

17. INFORMANT (ADDRESS) M. I. COOK Lebanon Mo.

18. BURIAL, CREMATION, OR REMOVAL - PLACE Highway Cem DATE 7-22-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) PALMERS LEBANON MO

20. FILED 7-21-39 J. A. McCoub Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 21ST 1939

22. I HEREBY CERTIFY That I attended deceased from Jan 10, 1936, to July 21, 1939

I last saw her alive on July 20, 1939 Death is said to have occurred on the date stated above, at 1:10 A.M.

The principal cause of death and related causes of importance were as follows:

Chronic interstitial nephritis

Date of onset \_\_\_\_\_

Other contributory causes of importance: 121

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? None Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify \_\_\_\_\_ (Signed) P. J. ..., M. D.

(Address) Lebanon Mo.

RECEIVED

District Health Officer No. 7,1168  
District File Number 7-29-1605  
Date Filed 8-9-29

---

---

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*W. S. Palmer*

Licensed Embalmer No. 1161

P. O. Address Lebanon 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 this body is not embalmed, above space should be left blank.**