

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.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: K.C. Gen. Hospital No. 3  
(d) Length of stay: In hospital or institution 2 days  
In this community About 30 Years

3. (a) PRINT FULL NAME Frederic Phillip Cook

3. (b) If veteran, name war World War Veteran 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ella L. Cook 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased March 27th, 1893

8. AGE:	Years	Months	Days	If less than one day
	<u>47</u>	<u>9</u>	<u>20</u>	hr. min.

9. Birthplace Dansville, Illinois

10. Usual occupation Radio Mechanic

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name James F. Cook  
13. Birthplace No Record  
14. Maiden name Mary Johnson  
15. Birthplace No Record

16. (a) Informant's own signature Mrs. Ella Cook  
(b) Address 1800 Lister Avenue, K.C. Mo.

17. (a) Burial (b) Date thereof Jan. 20-40

(c) Place: burial or cremation Green Lawn Cemetery

18. (a) Signature of funeral director Lrs. C. L. Forster  
(b) Address Kansas City, Mo.

19. (a) Jan. 19, 1940 (b) M. M. Crowe

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town Kansas City Missouri  
(d) Street No. 1800 Lister Avenue  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17th, 1940  
year 1940 hour 9 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1-15- 1940, to 1-17-40, 1940;  
that I last saw him alive on 1-17-40, 1940;  
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage, cerebral  
Due to Hypertension  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy See above

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury ?  
23. Signature Dr. De Maria MD (M. D. or other)  
Address Supt. K.C. Gen. Hospital Date signed \_\_\_\_\_

**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 me

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Denzil C. Brown

Licensed Embalmer No. 2724

P. O. Address Banner City, N.Y.

**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.**