

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

**16294**  
 Do not use this space.

**1. PLACE OF DEATH**

(a) County Stoddard Registration District No. 837  
 (b) Township Castor Primary Registration District No. 6099 Registered No. \_\_\_\_\_  
 (c) City or Avert, Mo. (d) Street No. \_\_\_\_\_ 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** JAMES T. COOK

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M. 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 Emma Cook  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 3, 1866  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 7 26

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 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) Missouri

FATHER 13. NAME Martin Cook

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

MOTHER 15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Not known

17. INFORMANT Paul Cook  
 (ADDRESS) Bloomfield, Mo. Route.

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Liberty cemetery DATE 4/30/1940

19. FUNERAL DIRECTOR (NAME) Chiles Und. Co.  
 (ADDRESS) Bloomfield, Missouri.

20. FILED May 7, 1940 Joemie Punch  
 Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/29/1940

22. I HEREBY CERTIFY, That I attended deceased from APR. 16 1940 to APR. 15 1940  
 I last saw him alive on APR. 15 1940 Death is said to have occurred on the date stated above, at 11:20 p.m.  
 The principal cause of death and related causes of importance were as follows:

SENILE DEBILITY

Date of onset

Other contributory causes of importance:

FRACTURE OF HIP

WAX.

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

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Rd. Davis, M.D.

(Address) BLOOMFIELD, MO.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD  
 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.

144 R  
1940

RECEIVED  
District Health Officer No. 2,  
District File Number 540-100  
Date Filed 5/9/40

**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.....  
Licensed Embalmer No.....  
P. O. Address.....

**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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16294

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 837

Primary Registration District No. 6099

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Stoddard  
(b) City or town Castor  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community..... (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME

James T. Cook

(b) If veteran, name war.....

(c) Social Security No.....

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....

(Month) (Day) (Year)

8. AGE:

Years 73 Months 7 Days 26 If less than one day hr. min.

9. Birthplace.....

(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

13. Birthplace.....

(City, town, or county) (State or foreign country)

14. Maiden name.....

15. Birthplace.....

(City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a).....

(Burial, cremation, or removal)

(b) Date thereof.....

(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

(a) May 7, 1940 (b) Loonie Panch

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Stoddard

(c) City or town Rural  
(If outside city or town limits write "RURAL")

(d) Street No.....  
(If rural, give location)

(e) If foreign born, how long in U. S. A.?..... years.

DEATH CERTIFICATION

20. DATE OF DEATH: Month 4 day 29  
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....;

that I last saw him alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?.....  
(City or town) (County) (State)

(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 R. S. Davis (M. D. or Other).....

Address Blairfield mo Date signed.....

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16294

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 837

Primary Registration District No. 6099

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Stoddard  
(b) City or town Caster, Twp  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME James T. Cook

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 26 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 29 year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_ and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Senile Debility  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions fracture of hip (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ACCIDENT  
(b) Date of occurrence JAN. 10, 1940  
(c) Where did injury occur CASTER TWP. STODDARD, MO (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? FARM (HOME) (Specify type of place)  
While at work? YES (e) Means of injury FALL

23. Signature D. L. Davis, M.D. (Date signed 10-14-40)  
Address BLOOMFIELD, MO

SUPPLEMENTARY