

No. 2
9-43
-17-39
X37825

State File No. _____

FILED JAN 29 1947

Primary Registration District No. 4049

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Centralia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Sarah Ann Cook

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 1. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife C.C. Cook 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 6 1861
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>86</u> | <u>0</u> | <u>6</u> | hr. _____ min. _____ |

9. Birthplace Montgomery Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER FATHER

12. Name Jake Curtis

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

14. Maiden name Clementine Subbett

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

16. (a) Informant Miss Henriene Cook

(b) Address Centralia

17. (a) Burial (b) Date thereof Jan. 14 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia

18. (c) Signature of funeral director Leon J. ...

(b) Address Centralia, Mo.

19. (a) Jan 25 1947 (b) Maud Mc Bride
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 12th
year 1947 hour 9 minute 45 A.M.

21. I hereby certify that I attended the deceased from June 23rd, 1945 to January 12th, 1947, and that death occurred on the date and hour stated above.

that I last saw her alive on January 11, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 12 days

Due to Trauma (fall) at home 12 days ago

Due to Arteriosclerosis 20 yrs

Other conditions arterial hypertension 25 yrs
(Include pregnancy within 3 months of death)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations 1868 **ADDITIONAL SUPPLEMENTARY INFORMATION**

Of autopsy 18

22. If death was due to external causes, fall (circle 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 0

23. Signature Leopold Lachance (M. D. or other) M.D.
Address Centralia, Mo. Date signed 1-12-47

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

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JAN 28 1947

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH

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 *George Jernigan*
Licensed Embalmer No. *4270*
P. O. Address *Centerville, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb
Registrar's No. 1

Registration District No. 37 Primary Registration District No. 4049

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Centralia
(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 _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Sarah A. Cook
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Jan 6 (Month) 1906 (Year)
8. AGE: Years 86 Months _____ Days _____ If less than one day _____ hr _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 _____

19. (a) _____ (Date received local registrar) (b) _____ (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; and that death occurred on the date and hour stated above.

Duration _____
Immediate cause of death _____
Due to _____
Due to _____
Other conditions: _____ (Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence January 1st, 1947
(c) Where did injury occur? Centralia, Boone, Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home
While at work? No (Specify type of place) (e) Means of injury slipping on the floor
23. Signature Joseph S. Schane (M. D. or other) M.D.
Address Centralia, Mo Date signed 2-7-47

SUPPLEMENTARY

WRITE PLAINLY - USE UNFADING INK - A PERMANENT RECORD

MOTHER FATHER

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