

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9363**

FILED MAR 25 1954

BIRTH NO. _____ REG. DIST. NO. **200** PRIMARY REG. DIST. NO. **4310** Registrar's No. **163**

1. PLACE OF DEATH a. COUNTY Macon		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission). a. STATE Mo b. COUNTY Macon	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Berwin Mo	c. LENGTH OF STAY (in this place) -	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Berwin Mo	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION -		d. STREET ADDRESS (If rural, give location) -	

3. NAME OF DECEASED (Type or Print) a. (First) SIDNEY b. (Middle) WASHINGTON c. (Last) COOKEY			4. DATE OF DEATH (Month) (Day) (Year) 3-14-54		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-4-78	9. AGE (In years last birthday) 75	If UNDER 1 YEAR: Months 6 Days 10
10a. USUAL OCCUPATION (Give kind of work one enjoys most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Berwin Mo		12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME Alexander Cooley		13b. MOTHER'S MAIDEN NAME Mary Peterson		14. NAME OF HUSBAND OR WIFE Alpha Albie Cooley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 486-725-138	17. INFORMANT'S SIGNATURE OR NAME Alpha Cooley ADDRESS Berwin Mo		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung			INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 163 X		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE James E. Campbell, M.D. (Degree or title)		23b. ADDRESS Macon Mo		23c. DATE SIGNED 3/18/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-16-54	24c. NAME OF CEMETERY OR CREMATORY West Oakwood Cem	24d. LOCATION (City, town, or county) (State) Berwin Mo	
DATE REC'D BY LOCAL REG. 3/19/54	REGISTRAR'S SIGNATURE Wm McNeely	185	25. FUNERAL DIRECTOR'S SIGNATURE H. S. Edwards ADDRESS Berwin Mo	

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

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RECEIVED 3.23.54
MACON COUNTY HEALTH DEPARTMENT
County File No. 3.54.41
Date Filed 3.25.54

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed *J. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Berlin, 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.