

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

8 MAY 25 1929

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.

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

Do not use this space.

14357

**1. PLACE OF DEATH**

County Scott

Registration District No. 309

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 4185

Registered No. 22

City Albany (No. \_\_\_\_\_)

St. \_\_\_\_\_

Ward \_\_\_\_\_

**2. FULL NAME** Cora Estella Cook

(a) Residence. No. \_\_\_\_\_

St. \_\_\_\_\_

Ward. \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**3. SEX**

F

**4. COLOR OR RACE**

W

**5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)**

M

**5A. If MARRIED, WIDOWED, OR DIVORCED**

HUSBAND or (OR) WIFE OF

Harry Meloni Cook

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)**

June 22 1895

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

33

9

14

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

Harrison Co. Mo

**10. NAME OF FATHER**

James Clayton

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Virginia

**12. MAIDEN NAME OF MOTHER**

Mollie J. Brown

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY)

Ill.

**14.**

INFORMANT

(Address)

Edgar Clayton  
Bethany Mo

**15.**

DATE

19

Mar 9 29 W. H. Madril  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)**

4-6-1929

**17.**

I HEREBY CERTIFY, That I attended deceased from 6-21, 1928, to 4-6, 1929, that I last saw him alive on 4-6, 1929, and that death occurred, on the date stated above, at 4:10 p.m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septicemia

**CONTRIBUTORY (SECONDARY)**

Septic Sore Throat (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 6 ds.

**18. WHERE WAS DISEASE CONTRACTED**

If NOT AT PLACE OF DEATH, \_\_\_\_\_

**DID AN OPERATION PRECEDE DEATH? DATE OF \_\_\_\_\_**

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) Frank W. Rose, M. D.

4-9-1929 (Address) Albany Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL**

**DATE OF BURIAL**

Bethany Mo. Mission Cemetery

4-8 1929

**20. UNDERTAKER**

L. W. Haas

**ADDRESS**

Bethany Mo

