

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

Do not use this space.

3220

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

File No.....

Township.....

Primary Registration District No.....

1003

Registered No. **E 820**

City **St Louis, mo.**

(No. **City 1147 nr**)

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

**2. FULL NAME**

**Baley Cooper #1**

(a) Residence. No. **927 W 12**

St. **25** Ward \_\_\_\_\_

(If nonresident give city or town and State)

Length of residence in city or town where death occurred \_\_\_\_\_ yrs. \_\_\_\_\_ mos.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How long in U.S., if of foreign birth? \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

**Male**

4. COLOR OR RACE

**negro**

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

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jun 4, 1927**

7. AGE

YEARS

MONTHS

DAYS

**1**

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

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer \_\_\_\_\_

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

(STATE OR COUNTRY) **mo.**

10. NAME OF FATHER **Dallas Cooper**

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

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Carrie Sengst**

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

(STATE OR COUNTRY)

14.

INFORMANT (Address) **Anna F. Woodard City Hospital #2**

15.

FILED **JAN 24 1927** **may 6 Starkeoff** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Jun 5 1927**

17.

I HEREBY CERTIFY, That I attended deceased from **Jun 5 1927**, to **Jun 5 1927**, that I last saw **him** alive on **Jun 5 sup 1927** and that death occurred, on the date stated above at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

**Premature Birth**

CONTRIBUTORY (SECONDARY) **159 16/100**

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **no** DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) **J. W. Gray**, M. D.

, 19 (Address) **City 1147 nr**

\*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

**POTTERS FIELD,**

DATE OF BURIAL

**1-27-1927**

20. UNDERTAKER

**J. S. Trotter**

ADDRESS

**2945 Lawton 131**

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.

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

