

APR 27 1927

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

Do not use this space.

8828

1. PLACE OF DEATH

County Livingstone
Township Chillicothe
City Chillicothe (No.) St. Ward)

Registration District No. 508
Primary Registration District No. 3024

File No.
Registered No. 34

2. FULL NAME Velma Verlie Cooper

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) L

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF L

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 5 1925

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.
1 | 5 | 20

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employee)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Livingston Co Mo

10. NAME OF FATHER Herbman Cooper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Livingston Co Mo

12. MAIDEN NAME OF MOTHER Effie McCracken

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Carroll Co Mo

14. INFORMANT Hersie Cooper (Address) Chillicothe Mo

15. FILED 3-26 1927 Barney REGISTRAR

V MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 25 1927

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1927, to March 25, 1927, that I last saw her alive on March 25, 1927, and that death occurred, on the date stated above, at 4:30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lobar pneumonia

7 108 (duration) yrs. mos. ds. 10

CONTRIBUTORY (SECONDARY) measles (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) R. J. Brennan, M. D.
3/26 1927 (Address) Chillicothe, 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 Blue Mound DATE OF BURIAL 3-27 1927

20. UNDERTAKER F B Norman Chillicothe ADDRESS

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.

