

JAN 22 1929

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

Do not use this space.

39711

1. PLACE OF DEATH
 County Cape Girardeau Registration District No. 125 ✓
 Township _____ Primary Registration District No. 3009
 City _____ (No. _____) St. _____ Ward _____
 2. FULL NAME Beatrice Coff (Cooper)
 (a) Residence No. R.F.D. # 2 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

File No. _____
 Registered No. 1286
 St. _____ Ward _____

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 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) _____
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 27
 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) Hemmer Mo.
 (STATE OR COUNTRY)
 10. NAME OF FATHER Peter Cooper
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Cal. Va.
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Ruth Surr
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) S. E. Mo.
 (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-21-21
 17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, (that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 10:20 A.M. d.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Influenza
11A
108
 CONTRIBUTORY (SECONDARY) Influenza (duration) yrs. mos. 2 da.
 (duration) yrs. mos. 2 da.

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? Paul D. Dwyer
 (Signed) O. L. Leubner, M. D.
 , 19____ (Address) Cape Girardeau

*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.

14. INFORMANT Mr. Peter Cooper
 (Address) R.F.D. # 2 Cape Girardeau
 15. FILED 1/1/29 C. W. Campbell REGISTRAR
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL Fairmount Cemetery DATE OF BURIAL 12-21-1928
 20. UNDERTAKER Al. Bruckoff ADDRESS Cape Girardeau Mo.

1944

1944

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

12-28
ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 135 File No. _____
 Township _____ Primary Registration District No. 3009 Registered No. 1286
 City _____ (No. _____ St. _____ Ward)

2. FULL NAME Beatrice Cooper

(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 S.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 24, 1928

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
3 27 _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____ (duration) yrs. mos. ds.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 2/5 29 W. K. Kumpfer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 21 19 28

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, that I last saw h. _____ alive _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 (Address)

*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

19

20. UNDERTAKER ADDRESS

N. E. every other year. If the date is not supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as far as possible. Exact statement of OCCUPATION is very important. A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-39711