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

Do not use this space.

2302

1. PLACE OF DEATH

County Lewis — Registration District No. 480 — File No.

Township Union — Primary Registration District No. 5645 — Registered No. 6

City ..... (No. ..... St. ..... Ward)

2. FULL NAME John Edwin 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25th 1860

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	11	-	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Camp Point, Ill.
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Joseph Cooper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Kenticky

12. MAIDEN NAME OF MOTHER Rebecca Henry

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Indiana.

14. INFORMANT Mrs Edwin Cooper
(Address) La Grange, Mo.

15. FILED 1/27, 1929 W S Ellery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jany 25 1929

17. I HEREBY CERTIFY, That I attended deceased from Jany 20, 1929, to Jany 25, 1929 that I last saw him alive on Jany 25, 1929, and that death occurred, on the date stated above, at 1.00 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Influenza

11 B

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 11 B

(duration) ..... yrs. ..... mos. ..... ds.

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

0 DID AN OPERATION PRECEDE DEATH? no DATE OF .....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) W S Ellery, M. D.

, 19 (Address) La Grange 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
La Grange	Jan 27 1929
20. UNDERTAKER	**ADDRESS**
A.A.Roberts	La Grange, M

oberts

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.