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

Do not use this space.

File No. 2625

Registered No.

1. PLACE OF DEATH

County: Morgan

Township: O Range

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

Registration District No. 597

Primary Registration District No. 5793

2. FULL NAME Robert G 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: Male

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) Feb 16. 1907

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	11	6	

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) Miller Co.
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Milton Cooper

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

12. MAIDEN NAME OF MOTHER Dora Lucas

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Linn Creek
(STATE OR COUNTRY) Mo

14. INFORMANT Milton Cooper
(Address) Waynham. Mo

15. FILED 1-23. 1929 .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 22 1929

17. I HEREBY CERTIFY, That I attended deceased from 1/13, 1929, to 1/22, 1929 that I last saw ~~him~~ alive on 1/19, 1929, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
11A
10A
(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Influenza
(duration) ..... yrs. ..... mos. 2 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) G. D. Walker, M. D
, 19 (Address) Eldon 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: Union Cem. Morgan Co. Mo
DATE OF BURIAL: 1-24 1929

20. UNDERTAKER: N A Gows
ADDRESS: Barnett. Mo

CAUSE OF DEATH: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1929 71 0 0 262 1 2 1

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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1. PLACE OF DEATH

County: Morgan — Registration District No.: 597 — File No.:

Township: Osage — Primary Registration District No.: 5-795 — Registered No.:

City: (No. , St. Ward)

2. FULL NAME: Robert G. 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: M

4. COLOR OR RACE: W

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

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.

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)
(STATE OR COUNTRY)

PARENTS

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 1/25, 1929 W L Hatter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

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WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D
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19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S-2625