

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

Do not use this space.

5390

1. PLACE OF DEATH

County Barry Registration District No. 5051 File No. 3
 Township Shell Knob Primary Registration District No. 28 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Drucilla E 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 Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 5-1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 | 1 | 17 | _____

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (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) Missouri

10. NAME OF FATHER John Brantley

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

12. MAIDEN NAME OF MOTHER Fannah Bayes

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

14. INFORMANT A E Cooper (Address) Shell Knob Mo

15. FILED Feb 7 1929 Emma Weddington REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1929, to Feb, 22nd, 1929 that I last saw her alive on Feb. 21, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis
83 D 75 10 (duration) yrs. mos. 88 da.

CONTRIBUTORY (SECONDARY) rubrum (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
 WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) to H McEadlin M. D.
 , 19 (Address) Shell Knob 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 McKeweenaw DATE OF BURIAL 2-24 1929

20. UNDERTAKER Horine Funeral Service ADDRESS Carroll Mo

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.

1929

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