

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

Do not use this space.

23217

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **501 Calava Ave.**) St. _____ Ward _____

File No. _____
 Registered No. **6690**
 St. _____ Ward _____

2. FULL NAME

Frances J. Cooper
 (a) Residence. No. **501 Calava** St., **5** 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 **White**
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **George H. Cooper**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 4, 1859**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
89 10 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 employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) **Bangor**
 (STATE OR COUNTRY) **Maine**

10. NAME OF FATHER **Charles H. Pond**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Bangor**
 (STATE OR COUNTRY) **Maine**

12. MAIDEN NAME OF MOTHER **Kenneth Colcord**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Bangor**
 (STATE OR COUNTRY) **New Hampshire**

14. INFORMANT **Sam H. Cooper**
 (Address) **Clayton Ave**

15. FILED **M. C. Bondy** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 21 1929**

17. I HEREBY CERTIFY, That I attended deceased from **April** 1929 to **June 21**, 1929 that I last saw her alive on **June 21**, 1929, and that death occurred, on the date stated above, at **10 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Embolism of coronary artery

Acute failure of heart respiration continued 65 min. yrs. mos. ds.

CONTRIBUTORY **Suicidality**
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **at home**
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) **Walter Fisher** M. D.

, 19 (Address) **3720 Washington**

*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

Crematorium **June 21 1929**

20. UNDERTAKER **Wagoner** ADDRESS **3621 Olive**

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.

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