

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

Do not use this space.

42148

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1063*  
(No. *City Infirmary*)

File No.....  
Registered No. *11855*  
St. *# D-2* (Ward)

**2. FULL NAME**

(a) Residence. No. *City Infirmary* St. ~~St. Louis~~ Ward. *13*

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**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) *May 2-1891*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, ..... hrs. or ..... min.  
*38 7 2*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. *Day Laborer*  
(b) General nature of industry, business, or establishment in which employed (or employer). *Odd jobs*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Missouri*  
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Marshall Cooper*

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

12. MAIDEN NAME OF MOTHER *Ella Smith*

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

14. INFORMANT *Mrs. Effinger*  
(Address) *421 1/2 Broadway St. St. Louis*

15. FILED *566 95 1929* *Miss C. Starkey*  
19... REGISTAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-4 1929*

17. I HEREBY CERTIFY, That I attended deceased from *11-1-29*, 19... to *12-4*, 19... that I last saw ~~him~~ alive on *12-4*, 19... and that death occurred, on the date stated above, at *6:15 A.* m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Chronic Nephritis*  
*131*  
*107A* (duration) *3* yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED *Ill*  
IF NOT IN PLACE OF DEATH...  
DID AN OPERATION PRECEDE DEATH... DATE OF...  
WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) *W. H. ...* M. D.  
*12-4, 1929* (Address) *5200 Cass*

\*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 *Oak Grove Cemetery* DATE OF BURIAL *12-6 1929*

20. UNDERTAKER *McLaughlin* ADDRESS *23 W. Lockwood*

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.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

287  
1  
2  
1

12/11/71

619