

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

Do not use this space.

**1. PLACE OF DEATH**

County Jackson Registration District No. 399  
 Township Kau Primary Registration District No. 1002  
 City Kansas City (No. 5607 Oak St.)

File No. 1241  
 Registered No. 5332  
 St. 532 Ward

**2. FULL NAME**

Alvin Willard Cooper  
 (a) Residence. No. 5607 Oak St. St. 6 Ward Chiang Mai, Siam  
 (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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>Mar. 12, 1859</u>		
7. AGE	YEARS	MONTHS
<u>70</u>	<u>10</u>	<u>2</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Missionary</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Presbyterian</u>		
(c) Name of employer		
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)		
<u>Alvin Cooper</u>		
10. NAME OF FATHER		
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>		
12. MAIDEN NAME OF MOTHER <u>Emma Manu...</u>		
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>New York</u>		
14. INFORMANT <u>Mrs. J. W. Shallen</u> (Address) <u>5607 Oak</u>		
15. FILED <u>1/17</u> 19 <u>30</u> <u>M. M. Crowe</u> REGISTRAR		

**MEDICAL CERTIFICATE OF DEATH**

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 14 1930

17. I HEREBY CERTIFY, That I attended deceased from 1-11, 1930, to 1-14, 1930 that I last saw him alive on 1-14, 1930, and that death occurred, on the date stated above, at 11:30 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral thrombosis  
82.0  
97

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 3 ds.

CONTRIBUTORY State Smile Arturo Selmanis (SECONDARY) (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

18. WHERE WAS DISEASE CONTRACTED? At home

IF NOT AT PLACE OF DEATH

DID NO OPERATION PRECEDE DEATH? NO DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
 (Signed) William A. Myers M. D.

\*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 Freeman's Receiving Vault DATE OF BURIAL 1/17/30

20. UNDERTAKER Freeman's Mortuary ADDRESS 104 West 42nd St.

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.

WHITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

199  
31  
2

Dr. W. W. Dwyer  
815 Stewart Bldg.  
2 to 4:30