

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

Do not use this space.

4965

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Wear Primary Registration District No. 16
City Kansas City (No. Kansas City Gen Hosp) St. _____ Ward)

File No. _____
Registered No. 619

2. FULL NAME

Varite Cooper
(a) Residence. No. 4503 Kensington 16 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 Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 1, 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
23 7 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Chief
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Charles H. Cooper
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Genevieve Wyatt
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Mo.

14. INFORMANT Re used Clerk
(Address) Kansas City Gen Hosp

15. FILED 7/10, 1930 M. M. Cooper
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-10-1930

17. I HEREBY CERTIFY, That I attended deceased from 2-9, 1930 to 2-10, 1930 that I last saw her alive on 2-10, 1930 and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic Cerebro spinal meningitis
18 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 214 (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Cent Lab Fund
(Signed) P. E. Williams, M.D.

2-10, 1930 (Address) Supt KC Gen Hosp
*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 Highland Park DATE OF BURIAL 2-11-30
19

20. UNDERTAKER O. V. Mast ADDRESS K. C. Mo

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.

