

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

Do not use this space.

11765

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St Joseph Mo. (No. 1001 Naves Baptist Hospital St. _____ Ward _____)
 2. FULL NAME Joseph Everett Cooper
 (a) Residence. No. _____ St. _____ Ward. Des Moines Iowa
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Catherine Cooper
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 22, 1890
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
39 4 21
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work. Railway Conductor
 (b) General nature of industry, business, or establishment in which employed (or employer) Freight Dept
 (c) Name of employer K.C. C.C. Interurban Ry.
 9. BIRTHPLACE (CITY OR TOWN) Warren County
 (STATE OR COUNTRY) Iowa
 10. NAME OF FATHER James Cooper
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Warren County
 (STATE OR COUNTRY) Iowa
 12. MAIDEN NAME OF MOTHER Hedie Jane Hendrix
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Warren County
 (STATE OR COUNTRY) Iowa

PARENTS

14. INFORMANT Charles Cooper
 Address Warren Co. Iowa
 15. FILED 15 1930 REGISTRAR [Signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13, 1930
 17. I HEREBY CERTIFY, That I viewed on viewed on
 _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 6:15 P m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Internal injuries received by falling between interurban R.R. Cars at St Joseph Mo.
 CONTRIBUTORY (SECONDARY) [Signature] (duration) yrs. mos. ds.
 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? clinical
 (Signed) R.W. Tadlock Coroner, M. D.
 _____/13, 1930 (Address) St Joseph 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 Indianola, Iowa DATE OF BURIAL April 14, 30
 20. UNDERTAKER Freeman Funeral Home ADDRESS 1946 Calloun

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.

