

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

Do not use this space.

1. PLACE OF DEATH

County Monticau
Township Museau
City Clarksburg Mo (No. _____)

Registration District No. 10971
Primary Registration District No. 4236

File No. 23619
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Mrs. Berilda Cooper
(a) Residence, No. Clarksburg, Mo. St. _____ Ward _____
(Usual place of abode)

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)

Divorced

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

John P. Cooper

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

4-15-1851

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day,hra. ormin.
<u>79</u>	<u>3</u>	<u>20</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

California Mo.

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14.

INFORMANT (Address)

Mrs Anna McFadden
Mouri Okla.

15.

FILED

7-24-1930 Jc Mantie

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17, 1930

17. I HEREBY CERTIFY, That I attended deceased from 5-13-1930, to 7-17-1930, that I last saw her alive on 7-17-1930, and that death occurred, on the date stated above, at 3:20 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

186B
174B
107A

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (SECONDARY)

Fracture of femur
Bronchopneumonias yrs. _____ mos. 7 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

(Signed) P. L. Farris, M. D.

7-17-1930 (Address) Clarksburg, 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

Masonic Cem,
Clarksburg Mo.

DATE OF BURIAL

July 19, 1930

20. UNDERTAKER

Max W. Smith

ADDRESS

Clarksburg Mo.

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.

AUG 26 1930

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Moniteau Registration District No. 1092 File No. _____
 Township _____ Primary Registration District No. 4236 Registered No. _____
 City Clarksburg No. _____ St. _____ Ward _____

2. FULL NAME

Mrs. Senelda Cooper
 (a) Residence No. _____ St. _____ 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Div.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____

(STATE OR COUNTRY)

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____

(STATE OR COUNTRY)

14.

INFORMANT _____
 (Address) _____

15.

FILED 7-24-30 Jemartin
 1930 REGISTERAR _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 17 1930

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

"Fall Down of The Stairs"
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY Fracture of femur
 (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH. DATE OF _____

WAS THERE AN AUTOPSY? 185

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 _____, 19____ (Address) _____

*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 _____

20. UNDERTAKER _____

ADDRESS _____

SUPPLEMENTARY

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-203619