OCT 28 1930

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

Do not use this space.

File No. 29685

Registered No.

1. PLACE OF DEATH
County Greene
Township N Jackson
City ~~Fair Grove~~ (No. ..... St. ..... Ward)
Registration District No. 944
Primary Registration District No. 5447 B

2. FULL NAME Wm H Cooper
(a) Residence. No. Fair Grove Mo 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. 12 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~~ Cora M Cooper

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 16 - 1864

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
66	0	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired —
(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) Canada

PARENTS
10. NAME OF FATHER Edwin J Cooper
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) France
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) France

14. INFORMANT Mrs Cora M Cooper
(Address) Fair Grove Mo

15. FILED 7-5 1930 ~~[illegible]~~ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-4-1930

17. I HEREBY CERTIFY, That I attended deceased from 9-4-1930 to 9-4-1930 that I last saw him alive on 9-4-1930 and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetic Convulsions
59
87 B
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Diabetes Mellitus
(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? Clinical
(Signed) Henry T. Knapp M. D.
9-4, 1930 (Address) Springfield

*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: Cedar Bluff Cemetery
DATE OF BURIAL: Sep 6 1930

20. UNDERTAKER: J W Klingner & Co
ADDRESS: Springfield Mo

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...carefully supplied. AGE ... should state ... forms, so that it may be properly classified ... very important.

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: Greene — Registration District No.: 944 — File No.: 14

Township: Jackson — Primary Registration District No.: 3447 B — Registered No.: 14

City: ..... (No. ....., ... St. ..... Ward)

2. FULL NAME: Wm H. Cooper

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(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: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Cora M Cooper

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 16 - 1864

7. AGE: Years 66 — Months * — Days 18 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(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): Canada

PARENTS

10. NAME OF FATHER: Edwin Cooper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): France

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): France

14. INFORMANT: Mrs. Cora M Cooper
(Address): Fair Grove Mo

15. FILED: Nov 11 - 1930 — Registrar: [signature]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 4 1930

17. I HEREBY CERTIFY, That I attended deceased from 9-4-1930 to 9-4-1930, that I last saw him alive on 9-4-1930, and that death occurred, on the date stated above, at 2 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetic Convulsions
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Diabetes Mellitus
..... (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? Clinical
(Signed) Henry F. Knobb, M. D
, 19 (Address) Springfield

*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: Cedar Bluff Cemetery — DATE OF BURIAL: Sept 6 1930

20. UNDERTAKER: Geo Klingner & Co — ADDRESS: Springfield Mo

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in medical 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

1930
29685