

WRITE CLEARLY, 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.

APR 26 1932

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

Do not use this space.  
*W. J. Ferrell*  
File No. 8087  
Registered No. 207

1. PLACE OF DEATH  
 39 County Greene Registration District No. 318  
 3 Township \_\_\_\_\_ Primary Registration District No. 2001  
 5 City Springfield (No. 1001) (Post Office Coop) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Charles B. Cooper  
 (a) Residence, No. 812 E. Cooper 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-17-1885

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.  
47 0 26

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Miller

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

13. NAME Chas B Cooper

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Alma Cooper

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pa

17. INFORMANT (ADDRESS) Wm. Arthur Good Beer  
812 E. Cooper

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE \_\_\_\_\_ 1932

19. UNDERTAKER (ADDRESS) Wm. J. Ferrell  
Springfield, Mo.

20. FILED 5-14-1932 For Sharp Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 13 1932

22. I HEREBY CERTIFY, That I attended deceased from 8/10 32, to 8/13 32, 1932  
 I last saw him alive on 3/12 32 Death is said to have occurred on the date stated above, at 3/13/32 3:30 A.M.  
 The principal cause of death and related causes of importance were as follows:  
New that wound 9 neck suicidal  
knife wounds 9 neck  
multiple pulmonary thrombi  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
Chronic tubular hepatitis  
secondary anemia

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? autopsy Was there an autopsy? yes

23. If death was due to external cause (violence), fill in also the following:  
 Accident, suicide, or homicide? suicide Date of injury 3/10 32  
 Where did injury occur? Springfield Mo.  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. in home

Manner of injury self-inflicted  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) W. J. Ferrell M. D.  
 (Address) 842 Medical Arts  
Springfield Mo.

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