

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

Do not use this space.

1. PLACE OF DEATH

9 County Ballinger Registration District No. _____ File No. 28453-A
Township Crooked Creek Primary Registration District No. 51 Registered No. _____
City Beesville (No. _____) St. _____ Ward _____

2. FULL NAME Samuel W. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 5 1861

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	71	7	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Farmer 131
(b) General nature of industry, business, or establishment in which employed (or employer). 92
(c) Name of employer 107

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa 2

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) 31

12. MAIDEN NAME OF MOTHER Dont Know

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

14. INFORMANT Price Cooper
(Address) Beesville, Mo.

15. FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH Sept 14 1932

16. DATE OF DEATH (MONTH, DAY AND YEAR) September 14 1932

17. I HEREBY CERTIFY, That I attended deceased from February 1932 to September 14, 1932 that I last saw him alive on September 14, 1932, and that death occurred, on the date stated above, at 10:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mitral regurgitation
Bronchial pneumonia (duration) 5 yrs. 3 mos. 3 ds.

CONTRIBUTORY Interstitial nephritis (SECONDARY) (duration) 5 yrs. 0 mos. 0 ds.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____ WAS THERE AN AUTOPSY? (1)

WHAT TEST CONFIRMED DIAGNOSIS (Signed) S. B. Vaughn, 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 Beesville Mo Union, Church DATE OF BURIAL Sept 16 1932 19 _____

20. UNDERTAKER H. Baker ADDRESS Beesville

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.

B 23 1932

FEB 9 1958