

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.

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

Do not use this space.

APR 26 1935

## 1. PLACE OF DEATH

County Jackson  
Township Kaw  
City Kansas City (No. 2640 Forest)

Registration District No. 399  
Primary Registration District No. 1002

File No. 9017  
Registered No. 559  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Virgil Cooper

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode)

Colorado Springs, Colorado  
(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) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 6, 1874

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .....hrs. or .....min.  
60 11 26

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

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) Missouri

13. NAME Joseph Cooper

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Kentucky

15. MAIDEN NAME Pochontas Bell

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Missouri

17. INFORMANT J. B. Lapaley  
(ADDRESS) 2640 Forest

18. BURIAL, CREMATION, OR REMOVAL PLACE Colorado Spgs DATE March 4, 1935

19. UNDERTAKER Shuler - Mr. Cleere  
(ADDRESS) 3235 Buchanan

20. FILED 3/2 1935 M. M. Crum  
Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 2, 1935

22. I HEREBY CERTIFY, That I attended deceased from March 1 - 1935 to March 2 - 1935

I last saw him alive on March 1 - 1935. Death is said to have occurred on the date stated above, at 8 A.M.

The principal cause of death and related causes of importance were as follows:

Chronic Tuberculosis (Pulmonary & vertebral (lumbar)) years  
23

Other contributory causes of importance:

Alcoholism 2 days

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? Chemical exam Was there an autopsy? N.O.

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_ (Signed) Herbert Tuffell M. D.  
(Address) 1125 Realt Bldg.

