

NOV 15 1937

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH 791

36010  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. **1008**  
(b) Township ..... Primary Registration District No. ....  
(c) City **St Louis** (d) Street No. **St. John? Hospital** Registered No. **9587**  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. ....  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

**Pearl Cooper**  
(a) Residence, No. **5661 Cabanne Ave** St. **5**  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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 **Walter Cooper**  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Mar 11th 1887**  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**50 7 2**  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**  
9. Industry or business in which work was done, as 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) **St. Louis Mo.**

FATHER 13. NAME **Richard Boese**  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

MOTHER 15. MAIDEN NAME **Augusta Woerheide**  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

17. INFORMANT **Walter Cooper**  
(ADDRESS) **5661 Cabanne Ave**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Calvary** DATE **Oct 16th 1937**

19. FUNERAL DIRECTOR **Stroot - Carroll**  
(ADDRESS) **4612 Natural Bridge Ave**

20. FILER **14 1937 J. Brebeck**  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct 13th 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Apr 24**, 19**37**, to **Oct 13**, 19**37**.  
I last saw him alive on **Oct 12 7.50am** 19**37**. Death is said to have occurred on the date stated above, at ..... m.  
The principal cause of death and related causes of importance were as follows:

**Primary Carcinoma of breast metastases**  
Date of onset **50**

Other contributory causes of importance:  
**Ch. Lungs**  
**Ch. Spine - Skull**

Name of operation **Radical breast** Date of **2/2/37**  
What test confirmed diagnosis? **Biopsy** Was there an autopsy? **No**

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? **No** Date of injury ..... 19.....  
Where did injury occur? **None**  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **None**  
Nature of injury **None**

24. Was disease or injury in any way related to occupation of deceased? **No**  
If so, specify **Chew miller**  
(Signed) **J. Brebeck**, M. D.  
(Address) **835 Mission Bldg**

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. 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.

899833

STATEMENT BY LICENSED EMBALMER

I, Frank H. Stroot, Licensed Embalmer No. 2265

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

L. E. ....

No. .... or by ..... Registered Apprentice No. ....

working under my personal supervision.

Signed Frank H. Stroot

Licensed Embalmer No. 2265

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**