

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

14901
 Do not use this space.

REC'D MAY 11 1939

1. PLACE OF DEATH **GREENE** Registration District No. **318**
 (a) County.....
 (b) Township..... Primary Registration District No. **2001**
 (c) City **SPRINGFIELD** (d) Street No. **Springfield Baptist Hospital** 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.
 (If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME **Dorothy Bernice Cooper**
 (a) Residence, No. **160** St. **20 N. 13th St. Sioux City** Iowa
 (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) **Single**
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov 1, 1919**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
19 5 21
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 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) **Washta Iowa**
 FATHER 13. NAME **Chancy Burton Cooper**
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Washta Iowa**
 MOTHER 15. MAIDEN NAME **Grace Adelia Payne**
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Bean Siding N. Dakota**
 17. INFORMANT (ADDRESS) **Mrs. C. B. Cooper 20 N. 13th St. Sioux City, Ia.**
 18. BURIAL, CREMATION, OR REMOVAL PLACE **Patterson Cemetery Bradleyville Mo.** DATE **4-23-39**
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) **H. H. Schreyer Springfield, Mo.**
 20. FILED **Apr 22 1939 Chas. George Mott Local Registrar.**

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **April 22, 1939**
 22. I HEREBY CERTIFY, That I attended deceased from **March 7, 1939, to April 22, 1939**
 I last saw him/her alive on **April 21, 1939**. Death is said to have occurred on the date stated above, at **3:28 A.M.**
 The principal cause of death and related causes of importance were as follows:
Gangrenous Appendicitis Date of onset **3/2/39**
 Other contributory causes of importance:
Ascending suppurative retro-aortal cellulitis + lymphangitis
Multiple Abscesses of Throat
 Name of operation **Appendectomy 3/19/39** Date of **3/2/39**
 What test confirmed diagnosis? **Antigen** Was there an autopsy? **yes**
 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? **No**
 If so, specify _____
 (Signed) **Durward G. Hall**, M. D.
 (Address) **500 Holland Bldg Springfield, Mo.**

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.

JAN 21 1946

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision. *Not Embalmed*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.)

If this body is not embalmed, above space should be left blank.

X