

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE 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.

Registration District No. 79i Primary Registration District No.

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution: City Infirmery
(d) Length of stay: In hospital or institution 19 days
In this community 72 years

3. (a) PRINT FULL NAME William Cooper
3. (b) If veteran, name war Unknown
3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 18 1868
(Month) (Day) (Year)

8. AGE: Years 72 Months 1 Days 8
If less than one day hr. _____ min. _____

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation None
11. Industry or business _____
12. Name Ben Cooper
13. Birthplace Unknown Unknown
14. Maiden name Mary McClain
15. Birthplace Unknown Unknown

16. (a) Informant's own signature [Signature]
(b) Address 5800 Arsenal St.
17. (a) Burial (b) Date thereof Mar. 27, 1940
(c) Place: burial or cremation Bellefontaine Cem
18. (a) Signature of funeral director [Signature]
(b) Address 25 Union Blvd.
19. (a) MAR 26 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 5800 Arsenal
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar. day 26
year 1940 hour 12:50 minute _____ A. M.
21. I hereby certify that I attended the deceased from Mar. 7, 1940, to Mar. 26, 1940
that I last saw him alive on Mar. 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Rupture of heart
Coronary occlusion
Due to arteriosclerosis
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations None
Of autopsy as above

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address 5800 Arsenal St. Date signed 3-26-40

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.

Signed.....

Licensed Embalmer No. 3575

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.