DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16209

MAY 15 1940

Registration District No. 796 Primary Registration District No. 4470 Registrar's No. 22

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.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Slater (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community all life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town Sh ter (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah Jane Cooper 160

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female

5. Color or race colored

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife X

6. (c) Age of husband or wife if alive X years

7. Birth date of deceased April (Month) 8th (Day) 1940 (Year)

8. AGE: Years X Months X Days 8 If less than one day hr. min.

9. Birthplace Slater (City, town, or county) Mo. (State or foreign country) 0

10. Usual occupation baby 0

11. Industry or business X 0

FATHER
12. Name Worda Cooper
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dear Mae Wright
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dear Mae Wright Cooper

(b) Address Slater Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 16-40 (Month) (Day) (Year)

(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Hill Bros. 709

(b) Address Slater Mo.

19. (a) 4 16 (Date received local registrar) (b) W. M. Tuttle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 16th year 1940 hour 2 minute 10 A M.

21. I hereby certify that I attended the deceased from 4-8-40, 19__, to 4-16-40, 19__; that I last saw her alive on 4-16-40, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Premature Infant.	
Due to 6 3/4 months	
Due to	
Other conditions (Include pregnancy within 3 months of death) 159	
Major findings: Of operations —	PHYSICIAN — Underline the cause to which death should be charged statistically.
Of autopsy —	

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? (Specify type of place)

While at work? — (e) Means of injury

23. Signature W. C. Dugger (M. D. or other)

Address Slater Mo Date signed 4-16-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 5-13-40

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~~
not embalmed
~~Registered Apprentice~~ No.
~~working under my personal supervision.~~

Signed Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater, Mo.

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

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