

STANDARD CERTIFICATE OF DEATH

State File No. 32736

Registration District No. 832

Primary Registration District No. 4382

Registrar's No. 39

1. PLACE OF DEATH:

(a) County Oregon(b) City or town Thayer - Mo.

(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 2In this community 25 years.3. (a) PRINT FULL NAME Mary Francis Cooper

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Fe 5. Color or race wh 6. (a) Single, widowed, married, divorced Widow6. (b) Name of husband or wife Osborn P. Cooper 6. (c) Age of husband, or wife if alive dead years7. Birth date of deceased Oct-1-18428. AGE: Years 97 Months 11 Days 25 If less than one day hr. _____ min. _____9. Birthplace Dresden - Ohio10. Usual occupation Domestic

11. Industry or business _____

12. Name Thomas Shilling13. Birthplace Kent - Co. England14. Maiden name Mary Unstead15. Birthplace Maryland16. (a) Informant J. D. Cooper(b) Address Thayer -17. (a) Burial (b) Date thereof 9-29-40(c) Place: burial or cremation Thayer18. (a) Signature of funeral director Les Carr(b) Address Thayer Mo.19. (a) Oct. 4 - 1940 (b) Kola E. Johnson

(Date received local registrar) (Registrar's signature) Deputy

(Licensed Embalmer's Statement on Reverse Side) Hull

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon(c) City or town Thayer(d) Street No. 0

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26 year 1940 hour 5 minute 35 p. M.21. I hereby certify that I attended the deceased from Sept 24, 1940, to Sept 25, 1940 that I last saw him alive on Sept 25, 1940 and that death occurred on the date and hour stated above.Immediate cause of death SenilityDue to ad-vent ageDue to NoneOther conditions None

Major findings: Of operations _____

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 563

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature H. B. Hull (M. D. or other) _____Address Mammoth Springs Mo Date signed 10/2/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

40
39
23159

RECEIVED

District Health Officer No. 5,

District File Number 104 01013

Date Filed

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.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.