No. 2
11-10-39
3-17-39
I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36743
9016

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

FILED DEC 11 1940

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County
(c) City or town St. Louis 21
(If outside city or town limits, write "RURAL")
(d) Street No. 2916 Pine Street
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sterling Cooper
3. (b) If veteran, name war
3. (c) Social Security No. 498-09-3482

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maxine Cooper
6. (c) Age of husband or wife if alive 27 years
7. Birth date of deceased May (Month) 17 (Day) 1910 (Year)

8. AGE: Years 30 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace (City, town, or county) Miss. (State or foreign country)
10. Usual occupation Laundry worker
11. Industry or business

MOTHER FATHER
12. Name Louis Cooper
13. Birthplace (City, town, or county) Miss. (State or foreign country)
14. Maiden name Bertha Ryland
15. Birthplace (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Madame Cooper
(b) Address 2916 Pine
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2-40 (Month) (Day) (Year)
(c) Place: burial or cremation Father Dickson Cem.
18. (a) Signature of funeral director Russell Undt. Co.
(b) Address 2732 Pine Street
19. (a) NOV 1 1940 (Date received by registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 30
year 1940 hour 10 Pm minute M.
21. I hereby certify that I attended the deceased from Oct 23 1940 to Oct 30 1940
that I last saw h~~e~~ alive on Oct 29th 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Nephritis	
caused by cystitis,	7 days
Probably tubercular	
Due to Suppression of Urine	
Acute Cystitis	7 or 8 days
Due to Prostatitis	?
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations No
Of autopsy

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature C. O. Robinson (M. D. or other)
Address 7611 Delmar Date signed Oct 31-40

(Licensed Embalmer's Statement on Reverse Side)

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 Joel Russell

Licensed Embalmer No. 4112

P. O. Address_____

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

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