

FILED MAY 16 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. 13587Registration District No. 399Primary Registration District No. 1002Registrar's No. 1568

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
General Hospital #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3-21-41-4-17-41
 (Specify whether
 years, months or days) 11 years

In this community Dosie
 years, months or days
 3. (a) PRINT FULL NAME Dorothy Hudson Cooper

8. (b) If veteran, name war None
 8. (c) Social Security No. None

4. Sex Female 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive 14 years

7. Birth date of deceased 2 (Month) 14 (Day) 1893 (Year)

8. AGE: Years 47 Months 2 Days 3
 If less than one day hr. min.

9. Birthplace Magnolia Arkansas
 (City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER
 { 12. Name Unk James Burns
 { 18. Birthplace Unknown La.
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Ida Parham
 { 15. Birthplace La.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature R cord Clerk

(b) Address Gen. Hosp. #2

17. (a) burial (b) Date thereof 4/21/41
 (Burial, cremation, or removal) (Month, Day, Year)
Lincoln Cemetery

(c) Place: burial or cremation

18. (a) Signature of funeral director Watkins T Brad
1729 Lydia

(b) Address

19. (a) Apr 21 1941 (b) M. M. Crow
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1701 E. 17th St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 17
 year 41 hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from 3-21-, 1941 to 4-17-, 1941;
 that I last saw her alive on 4-17-, 41;
 and that death occurred on the date and hour stated above.

Immediate cause of death
Primary Adeno Carcinoma of Cervix

Due to Generalized Carcinomatosis

Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy Above Mentioned

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 R. D. [unclear] (M. D. or other)
 Address Gen. Hosp. #2 Date signed 4-18-41

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.

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.....

J. Manlove

Licensed Embalmer No. *3994*

P. O. Address *1120 E. 23rd St.*

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.