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7-39  
X26390

**FILED** AUG 28 1941  
Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer C. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 21 days  
In this community 23 yrs. 0 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Hiram Cooper  
3. (b) If veteran, name war -----  
3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Virlee Cooper  
6. (c) Age of husband or wife if alive 36 years  
7. Birth date of deceased September 23d 1898  
(Month) (Day) (Year)

8. AGE: Years 42 Months 9 Days 11  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Mexico Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business Drug-Store

MOTHER FATHER { 12. Name Elijah Cooper  
13. Birthplace Mexico Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary E. Belle  
15. Birthplace Mexico Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Virlee Cooper  
(b) Address 4237a West Belle Pl.

17. (a) Burial (b) Date thereof 7/3/41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. Bates  
(b) Address 4107 Finney Ave.

19. (a) JUL 2 1941 (b) J. W. ...  
(Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4237 W. Belle  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month June day 30  
year 1941 hour 6:45 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from June 9 1941 to June 30 1941  
that I last saw him alive on June 30 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Glomerular Nephritis Duration 12 Mos

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_  
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? \_\_\_\_\_

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

23. Signature James W. Johnson (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier Date signed 7/1/41

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

770  
79

000  
17  
119

MOTHER FATHER

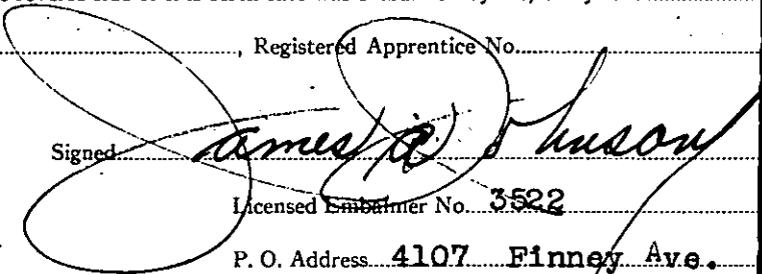
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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....**James A. Johnson**....., Registered Apprentice No.....  
working under my personal supervision.

Signed



.....**James A. Johnson**.....  
Licensed Embalmer No. **3522**  
P. O. Address **4107 Finney Ave.**

**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.**