

FILED MAR 19 1942

State File No.

Registration District No.

839

Primary Registration District No.

4510

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Essex *June*
(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Years
In this community 2 Years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Essex
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME JOE COOPER Jr.

3. (b) If veteran, name war --- 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased (Not known) 1864
(Month) (Day) (Year)

8. AGE: Years 78 Months --- Days --- If less than one day --- hr. --- min.

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

10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER { 12. Name Joe Cooper Sr.
13. Birthplace --- Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Kathryn Hendley
15. Birthplace North Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Bob Cooper
(b) Address Dexter, Mo. Route # 1.

17. (a) Burial Bloomfield, Mo. (b) Date thereof 2-21-1942
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bloomfield, Mo.

18. (a) Signature of funeral director County Home Burial
(b) Address Stoddard Co. Mo

19. (a) 3-9-42 (b) Nora Jones
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20th
year 1942 hour 1 P. M. minute --- M.

21. I hereby certify that I attended the deceased from --- 19 --- to --- 19 ---
that I last saw h --- alive on --- 19 ---
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 6-20 hrs

Due to Paralytic Stroke

Due to ---
Other conditions ---
(Include pregnancy within 3 months of death) 107

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? 9

While at work --- (Specify type of place)
Means of injury ---
23. Signature J. A. Gibbs Coroner 2-21-42
(M.D. or other)
Address Bloomfield Missouri Date, signed ---

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

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 Deceased was not embalmed.

Licensed Embalmer No.....

P. O. Address.....

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, fact should be so stated above.