

U.S. No. 2  
M-9-4-41  
Rev. 5-17-39  
I X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

9538

State File No. ....

FILED APR 25 1942  
399

Registration District No. ....

Primary Registration District No. 100

Registrar's No. 1314

1. PLACE OF DEATH:

(a) County Jackson,  
Kansas City,

(b) City or town.....  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Joseph Hospital, 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day, (Specify whether  
years, months or days)

In this community 1 day,

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County Jackson, 042  
3

(c) City or town..... Kansas City, 2  
(If outside city or town limits, write "RURAL")

(d) Street No. 3812 Wabash,  
(If rural, give location)

(e) Citizen of foreign country? X (Yes or No)  
If yes, name country X 0

3. (a) PRINT FULL NAME Kathryn Owen Cooper,

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced. Infant 0

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

7. Birth date of deceased. April 2 1942  
(Month) (Day) (Year)

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

9. Birthplace. Missouri, 0  
(City, town, or county) (State or foreign country)

10. Usual occupation X

11. Industry or business X

12. Name J. C. Cooper,

13. Birthplace Missouri, 0  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Hickman,

15. Birthplace Missouri, n  
(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Hickman,

(b) Address 3812 Wabash, Kansas City, Mo.

17. (a) Removal, (b) Date thereof 4-4-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boonville, Mo.

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 4/3/42 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3rd  
year 1942 hour 2:30 minute P. M.

21. I hereby certify that I attended the deceased from Apr 2 1942 to Apr 3 1942  
that I last saw he alive on Apr 3 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Atelectasis 24 hrs.

Due to Improper expansion of lungs following birth.

Due to 161a

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....

Duration

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).....  
..... means of injury.....

23. Signature William M. Kott (M. D. or other) MD.  
Address 612 Professional Bldg Date signed Apr 3/42

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

42  
3  
8

361

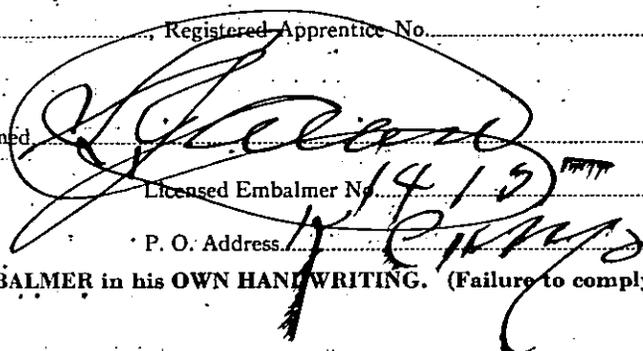
Dr. Karth

6935 - Riverside Rd.

**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. 1412

P. O. Address

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

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