DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 28 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25395

Registration District No. 193

Primary Registration District No. 4497

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: No
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 50 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Slater
(If outside city or town limits, write "RURAL")

(d) Street No. East Emma St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? x years.

3. (a) PRINT FULL NAME Sarah Alice Cooper

3. (b) If veteran, name war x

3. (c) Social Security No. x

4. Sex Female

5. Color or race Wh.

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 28 (Day) 1859 (Year)

8. AGE: Years 82 Months 7 Days 23 If less than one day hr. min.

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

10. Usual occupation Clerk

11. Industry or business Retired Grocery

FATHER
12. Name Elijah Cooper
13. Birthplace (City, town, or county) Ky. (State or foreign country)

MOTHER
14. Maiden name Mary Jane Deckard
15. Birthplace (City, town, or county) Ky. (State or foreign country)

16. (a) Informant's own signature Mrs. Frank Gabb
(b) Address Slater Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/42 (Month) (Day) (Year)
(c) Place: burial or cremation Slater Mo.

18. (a) Signature of funeral director Hill Brothers
(b) Address Slater Mo.

19. (a) 7/24/42 (Date received local registrar) (b) Mrs. John Giger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 22
year 1942 hour 7 minute a. M.

21. I hereby certify that I attended the deceased from July 1 - , 1930, to July 27, 1942
that I last saw her alive on July 20, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

Due to

Due to

Other conditions 162 b
(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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature O. W. Caldwell (M. D. ~~Dentist~~)
Address Slater Mo. Date signed 7-22-42

1211

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Rev. 8-17-39 I X19511

RECEIVED

[illegible] Health Officer No. 8,

[illegible] File Number .....

Date Filed 7-27-42

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 Sam M Hill

Licensed Embalmer No. 1292

P. O. Address Slater Mo

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.