

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED SEP 11 1942

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 804

1. PLACE OF DEATH:

(a) County Bushanan

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

(c) Name of hospital or institution: St Hosp #2 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 mos 8 days  
(Specify whether)

In this community 70 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

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

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

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

3. (a) PRINT FULL NAME CLAUDE C COOPER

3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

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

6. (b) Name of husband or wife Mrs. Claude Cooper 6. (c) Age of husband or wife if alive, years

7. Birth date of deceased. (Month) (Day) (Year)

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

71 6 24 hr. min.

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

10. Usual occupation Laborer

11. Industry or business

12. Name Claude Cooper

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

14. Maiden name Walker

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

16. (a) Informant Mrs. Claude Cooper

(b) Address Chillicothe Mo

17. (a) Removal (b) Date thereof 8-18-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director James D. Gindner

(b) Address Chillicothe Mo

19. (a) 8-18-42 (b) Rose Heizer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18  
year 1942 hour 1 minute 00 a.m.

21. I hereby certify that I attended the deceased from April 10 1942 to August 18 1942  
that I last saw him alive on August 17 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Gangrene of left foot & leg  
Duration 6-5-42

Due to Arteriosclerosis 98% ✓  
Due to

Other conditions Hypertensive Cardiovascular Disease  
(Include pregnancy within 3 months of death)

Major findings: Gangrene of left foot & leg due to arteriosclerosis & thrombosis

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? .....

(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 D.P. Johnson (M. D. or other) M.D.  
Address State Hosp #2 Date signed 8-18-42

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

11  
7

1233

(Licensed Embalmer's Statement on Reverse Side)

St Joseph, Mo

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Donald F. Gordon*  
Licensed Embalmer No. *4191*  
P. O. Address *Phillips, 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, fact should be so stated above.**