

S. No. 2  
-1-4-41  
5-17-39  
X28390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

6507

LED MAR 8 1943

Registration District No. 141

Primary Registration District No. 3025

State File No.

Registrar's No. 191

1. PLACE OF DEATH:

(a) County Howell  
(b) City or town West Plains  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: West Plains Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community 1 week  
years, months or days)

3. (a) PRINT FULL NAME Berniece Burns Cooper

3. (b) If veteran, name war

3. (c) Social Security No. None

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

6. (b) Name of husband or wife Hugh Cooper 6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased June 30 1909  
(Month) (Day) (Year)

8. AGE: Years 35 Months 7 Days 23 or min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name Jim Burns

13. Birthplace Franklin Arkansas  
(City, town, or county) (State or foreign country)

14. Maiden name Alice Almada Beaver

15. Birthplace West Hill Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Hugh Cooper

(b) Address Salem Arkansas

17. (a) Burial (b) Date thereof 2-26-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Ark. Cemetery

18. (a) Signature of funeral director Hugh Cooper

(b) Address Salem Ark.

19. (a) 2-22-43 (b) Paul Stasler  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Fulton  
(c) City or town Salem  
(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 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 22  
year 1943 hour 12 minute 30 P M.

21. I hereby certify that I attended the deceased from 2/22 1943 to 2/22 1943  
that I last saw h. or alive on 2/22 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy 5 hrs  
nephritis acute 2 hrs  
Belaupeia 5 hrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Cerebral section  
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) 1  
(b) Date of occurrence  
(c) Where did injury occur? X (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? X (Specify type of place) (e) Means of injury 0

23. Signature Maurice Hampton (M. D. or other)  
Address West Plains Mo Date signed 2/24/40

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

MOTHER FATHER

1123

RECEIVED

District Health

District File Number

Date Filed

3543130  
2-6-43

**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.....

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.**