

17-39
X32873

FILED APR 2 1943
Registration District No. 338

Primary Registration District No. 6147

Registrar's No.

1. PLACE OF DEATH:
(a) County. Stoddard
(b) City or town. Bloomfield, Rural # 1
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. -----
In this community Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State. Mo. (b) County. Stoddard
(c) City or town. Bloomfield Rural
(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. -----

3. (a) PRINT FULL NAME CHARLEY COOPER
3. (b) If veteran, name war. ----- 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 9th
year 1943 hour 7:15 minute A. M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife. Mrs. Victoria Cooper 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased Sept. 5, 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from January 1943 to March 9, 1943
that I last saw him alive on March 8, 1943
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>5</u>	<u>15</u>hr.min.

Immediate cause of death. Apoplexy
Due to Hypertension
Due to Arteriosclerosis

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

Other conditions. (Include pregnancy within 3 months of death) 83a
Major findings:
Of operations -----
Of autopsy -----

10. Usual occupation Farmer
11. Industry or business -----
12. Name Jeptha Cooper
13. Birthplace ----- / Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Margaret Glover
15. Birthplace ----- / Mo.
(City, town, or county) (State or foreign country)

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) -----
(e) Means of injury -----

16. (a) Informant Vader Cooper
(b) Address Swinton, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 14-43
(Month) (Day) (Year)
(c) Place: burial or cremation. Oak Ridge cemetery
18. (a) Signature of funeral director. Chiles Und. Co.
(b) Address Bloomfield, Mo.
19. (a) ----- (b) -----
(Date received local registrar) (Registrar's signature)

23. Signature E. C. Masters (M. D. or other) Doc.
Address Advance, Mo. Date signed 3/22/43

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

MOTHER FATHER

1130

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 *Wm. C. Cooper*.....

Licensed Embalmer No. 4119.....

P. O. Address. Bloomfield, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11603

Registration District No. 338

Primary Registration District No. 6148

Registrar's No.

1. PLACE OF DEATH: *Stoddard rural*

(a) County.....

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

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

(d) Length of stay: In hospital or institution..... (Specify whether)

In this community.....
years, months or days

3. (a) PRINT FULL NAME *Charley Cooper*

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

4. Sex..... *m* 5. Color or race..... *w* 6. (a) Single, widowed, married, divorced..... *m*

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

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

8. AGE: Years *64* Months *5* Days..... If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

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

{ 14. Maiden name.....

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

16. (a) Informant..... (b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) *5/3/1943* (b) *Pearl E. Moore*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town..... (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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *March* year *1943* hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19.....; that I have seen him..... alive on....., 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

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) (e) Means of injury.....

23. Signature..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-11653