

Registration District No. 10374

Primary Registration District No. 3035

Registrar's No. 35

54  
23  
28

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

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution: City 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 56 yrs. years, months or days)

3. (a) PRINT FULL NAME MARTHA O. COOPER

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

4. Sex Fe 5. Color or race W

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

6. (b) Name of husband or wife Joseph B. Cooper 6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased July 27 1895  
(Month) (Day) (Year)

8. AGE: Years 67 Months 9 Days 20 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation at home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name James Mc Gowan

13. Birthplace Not known?  
(City, town, or county) (State or foreign country)

14. Maiden name Not known

15. Birthplace Not known?  
(City, town, or county) (State or foreign country)

16. (a) Informant Joseph B. Cooper

(b) Address Luxington, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16-1943  
(Month) (Day) (Year)

(c) Place: burial or cremation Luxington, Mo

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

(b) Address Luxington, Mo

19. (a) June 2-43 (Date received local registrar) (b) Mrs. Fred Schwab (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

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

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

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13  
year 1943 hour 1 minute 50 P. M.

21. I hereby certify that I attended the deceased from May 1 1943 to May 13 1943  
that I last saw her alive on May 13 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Malignant disease probably of liver Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to H&F

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy None

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) (e) Means of injury \_\_\_\_\_

23. Signature W. F. Redin (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

*Excluded*

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-8-43

**JUN 17 1943**

**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 *J. W. P. [Signature]*

Licensed Embalmer No. 1983

P. O. Address *[Signature]*

**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.**