

FILED JUN 22, 1924

Registration District No. 17

Primary Registration District No. 1002

Registrar's No. 2418

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution:  
45 East 32nd Street  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Dorothy Jean Cooper

3. (b) If veteran, name war no 3. (c) Social Security No. 500-14-1322

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

6. (b) Name of husband or wife Jakē Cooper 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased Oct 11th 1924  
(Month) (Day) (Year)

8. AGE: Years 19 Months 7 Days 23 If less than one day hr. min.

9. Birthplace Sapulpa Oklahoma  
(City, town, or county) (State or foreign country)

10. Usual occupation Howard Plastic CO

11. Industry or business 2600 Grand Ave

12. Name Edward McArtor

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

14. Maiden name Elna Arnett

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

16. (a) Informant Mrs. Elna McArtor

(b) Address 418 East 9th St

17. (a) Burial (b) Date thereof June 7th 1924  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Eylar Funeral Home

(b) Address 1800 Linwood

19. (a) 6-7-24 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City Missouri  
(If outside city or town limits write "RURAL")  
(d) Street No. 418 East 9th Street  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 4 year 44 hour 6 minute 40 P M.

21. I hereby certify that attended the deceased from at home, 1924

that I last saw him alive on 1924

and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxiation due to

obstruction of the

trachea.

Due to Asphyxiation due to

obstruction of the

trachea.

Other conditions fracture of the

(Include pregnancy within 3 months of death)

ADDITIONAL

Major findings: SUPPLEMENTARY

Of operation fracture of the

Of autopsy fracture of the

trachea.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Asphyxiation

(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) (a) Means of injury

23. Signature W. E. Keen 6/6/24

Address Keen 3 Date signed

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

**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

*Shirley C. Heck*

Licensed Embalmer No. *4063*

P. O. Address *1800 Sunwood*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 20532

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2418

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(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 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dorothy Jean Cooper  
3. (b) If veteran, name war  
3. (c) Social Security No.

4. Sex  
5. Color or race  
6. (a) Single, widowed, married, divorced  
6. (b) Name of husband or wife  
6. (c) Age of husband, or wife, if alive  
7. Birth date of deceased (Month) (Day) (Year)

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

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

10. Usual occupation

11. Industry or business

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

(c) Place: burial or cremation

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

19. (a) (b) (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) If foreign born, how long in U. S. A. years.

19. MEDICAL CERTIFICATION  
20. DATE OF DEATH: June 4  
year hour minute M.  
21. I hereby certify that I attended the deceased from 19 to 19  
that I last saw him alive on 19  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Acute Pulmonary Edema & Congestion  
Due to Petechial Hemorrhage of Brain  
Due to Positive findings for choral hydrate in gastric contents  
Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations.

Of autopsy ADDITIONAL SUPPLEMENTARY INFO ON RECORD 1952 GA

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Unknown  
(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) (Specify means of injury) Unknown

23. Signature A. E. Warner (M. D. or other) 23 May Date signed

SUPPLEMENTARY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

