S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 13 1944

Registration District No. 1

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5009

State File No. 27053

Registrar's No.

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Wilson Twp.
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Wilson Twp
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hattie Cooper
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harry Cooper
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct (Month) 2 (Day) 1865 (Year)
8. AGE: Years 78 Months 9 Days 26 If less than one day hr. min.
9. Birthplace Burma (City, town, or county) N.Y. (State or foreign country)
10. Usual occupation house wife
11. Industry or business
FATHER
12. Name Henry Gladhill 4
13. Birthplace # (City, town, or county) England (State or foreign country)
MOTHER
14. Maiden name Hannah Hallett 4
15. Birthplace (City, town, or county) England (State or foreign country)
16. (a) Informant Harry Cooper
(b) Address Gibbs Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof July 29-44 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Tabor Cem
18. (a) Signature of funeral director Albert Skinner
(b) Address Macon Mo
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28 year 1944 hour 9:45 minute a M.
21. I hereby certify that I attended the deceased from 31 July, 1939 to 3 Nov, 1943 that I last saw her alive on 3 Nov, 1943; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Metastatic Carcinoma	One year
Due to Carcinoma of spine	5 years
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

55 b

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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature E. Sisbern Smith MD (M. D. ~~or other~~)
Address Kirksville Mo Date signed 7/31/44

1044

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-44-1606
Date Filed SEP 12 1944

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 Cecil Skinner

Licensed Embalmer No. 751

P. O. Address Macon 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.

S. No. 2B
OM—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept.

Registration District No. 1 Primary Registration District No. 5009 Registrar's No.

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural - Wilson Twp.
(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)

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

3. (a) PRINT FULL NAME Hattie Cooper

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 Oct. (Month) 2 (Day) 1866 (Year)

8. AGE: Years 78 Months 9 Days 2 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
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) (Date received local registrar) (b) Mrs. J.L. Waquin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 28
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
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)

(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)
While at work? (e) Means of injury

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

SUPPLEMENTARY

27053