

FILED NOV 10 1944

Registration District No. ....

Primary Registration District No. 1554

Registrar's No. ....

6000  
WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
 (a) County Howell  
 (b) City or town HOCOMO, Missouri  
 (c) Name of hospital or institution: 1 1/2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 40 yrs.  
 In this community 40 yrs.  
 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Howell  
 (c) City or town HOCOMO, Missouri  
 (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 0

3. (a) PRINT FULL NAME Alice Russell Cooper

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

4. Sex F 5. Color or race W  
 6. (a) Single, widowed, married, divorced M  
 6. (b) Name of husband or wife J. C. Cooper  
 6. (c) Age of husband or wife if alive 82 years  
 7. Birth date of deceased April 8 1877  
 (Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 28  
 If less than one day hr. .... min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER  
 12. Name Jas. Brickey  
 13. Birthplace Kentucky (City, town, or county) (State or foreign country)  
 14. Maiden name unk  
 15. Birthplace unk (City, town, or county) (State or foreign country)

16. (a) Informant L. F. Cooper  
 (b) Address Hocomo, Missouri

17. (a) B (b) Date thereof 10-6-44  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Amy

18. (a) Signature of funeral director Robertson  
 (b) Address West Plains, Missouri

19. (a) 10/12-44 (b) [Signature]  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6  
 year 1944 hour 2 minute 55R.

21. I hereby certify that I attended the deceased from Sept 20 1944 to Oct 6 1944  
 that I last saw her alive on Oct 4 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy  
 Duration 2 wk

Due to Hypertension

Due to [Signature]

Other conditions [Signature]  
 (Include pregnancy within 3 months of death)

PHYSICIAN  
 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 [Signature] (M. D. or other) [Signature]  
 Address [Signature] Date signed 10-11-44

RECEIVED

District Health Officer No. 5,

District File Number 1144544

Date Filed 11-8-44

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

*Lawrence D. Roberts*

Licensed Embalmer No. 3435

P. O. Address West Valley, N.C.

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.