No. 2
1—5-43
5-17-39
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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. 22875

FILED AUG 13 1945

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3238

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: MENORAH 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ~~6-29-43~~ 10 WEEKS (Specify whether
In this community ~~7-8-45~~ 73 YRS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City Mo 3
(If outside city or town limits, write "RURAL")

(d) Street No. 9 E 34 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME MRS MARY Elizabeth COOPER

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex F 1

5. Color or race Wh

6. (a) Single, widowed, married, divorced Mdow 7

6. (b) Name of husband or wife John C Cooper

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

7. Birth date of deceased July (Month) 8 (Day) 1872 (Year)

8. AGE: Years 73 Months 0 Days 24 If less than one day hr. min.

9. Birthplace Kansas City (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Patrick Delaney
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 0 (State or foreign country)

16. (a) Informant John W. Cooper 1

(b) Address 9 E 34

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July (Month) 3 (Day) 1945 (Year)

(c) Place: burial or cremation Elmwood Cem

18. (a) Signature of funeral director Mrs C L Foster

(b) Address 918 Brooklyn

19. (a) 8-2-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ~~July~~ Aug. day 2 year 1945 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from May 29 1945, 19 , to 8.1 1945 that I last saw her alive on 8.1 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma Ascending Colon	1 year
Myocardial Decompensation	6 wks
Due to	
Due to 46 x	
Other conditions: Abscess right mid lobe lung (Include pregnancy within 3 months of death)	6 wks

Major findings: Of operations Carcinoma right colon

Of autopsy Abscess of lung
Myocardial Decompensation

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) no

(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 Hay C. Lapp (M. D. or other) M.D.

Address 1103 Grand Date signed 8-2-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 2570

P. O. Address. KC 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.