

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jasper

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

(c) Name of hospital or institution:  
Joplin General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community 25 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper

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

(d) Street No. 2129 Joplin  
(If rural, give location)

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

3. (a) PRINT FULL NAME Mary L 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 married

6. (b) Name of husband or wife Albert Cooper 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased June 15, 1890  
(Month) (Day) (Year)

8. AGE: Years 55 Months 3 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name John Moore

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

14. Maiden name Mary Lumford

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

16. (a) Informant Albert Cooper

(b) Address 2129 Joplin, Joplin, Mo

17. (a) Burial (b) Date thereof 11-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope

18. (a) Signature of funeral director Parker-Hunsaker

(b) Address 1502 Joplin, Joplin, Mo

19. (a) 11-14-45 (b) Ed. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 10<sup>th</sup> day 11 year 1945 hour 12:00 minute 50 A.M.

21. I hereby certify that I attended the deceased from Nov. 9<sup>th</sup> 1945 to Nov. 10, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Heart & Respiratory failure

Due to Hepatitis

Due to Cholecystitis

Other conditions (Include pregnancy within 3 months of death)

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

Of autopsy \_\_\_\_\_

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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)

(c) Means of injury \_\_\_\_\_

23. Signature C. E. [Signature] (M.D. or other)

Address Joplin, Mo. Date signed Nov. 10 '45

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

MOVIER FATHER

45-11-893

DEC - 5 1948

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 F. M. Jones  
Licensed Embalmer No. 2319  
P. O. Address Joplin 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See

Registration District No. 156

Primary Registration District No. 2001

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town Joplin  
(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)

3. (a) PRINT FULL NAME Mary L. 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 \_\_\_\_\_

7. Birth date of deceased June 15 (Month) (Day) (Year)

8. AGE: Years 55 Months 3 Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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 \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature W.E. Heinle \_\_\_\_\_

Address Joplin \_\_\_\_\_ Date signed 12-5-45

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

SUPPLEMENTARY

37529