

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12222**

Registrar's No. **415**

**FILED MAY 4 8 1946**

Registration District No. **42**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Missouri Methodist Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **8 hours**  
(Specify whether  
In this community **28 years**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **6402 Sherman St.**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **St. Joseph**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **Cecil Mollie Cooper**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Charles** 6. (c) Age of husband or wife if alive, dead **17, 1889**  
7. Birth date of deceased **May 17, 1889**  
(Month) (Day) (Year)

8. AGE: Years **56** Months **10** Days **22** If less than one day hr. min.

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

10. Usual occupation **Housekeeper**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **Charles Decker**  
13. Birthplace **Versailles, Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Alice Slivey**  
15. Birthplace **Versailles, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Albert Jones,**  
(b) Address **St. Joseph, Missouri**

17. (a) **Burial** (b) Date thereof **4/11/46**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **I.O.O.F. Cemetery**

18. (a) Signature of funeral director **John E. Crump**

(b) Address **6054 Pryor Ave., City**

19. (a) **April 12, 1946** (b) **[Signature]**  
(Date received local registrar) (Registrar's signature) (By V.H.)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **9,**  
year **1946** hour **3** minute **00 P.M.**

21. I hereby certify that I attended the deceased from **March 6,**  
**1946,** to **April 9,** 19**46**  
that I last saw her alive on **April 9,** 19**46**  
and that death occurred on the date and hour stated above.

Immediate cause of death **acute lymphatic leukemia** Duration **6 weeks**

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **746**

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 **Brown J. Roseenthal** (M. D. or other) **MD.**

Address **Chas. S. Surg. Bldg. Springfield** Date signed **April 3, 1946**

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

11-31

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**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,         

          
working under my personal supervision.

Registered Apprentice No.         

Signed John E. Kuff

Licensed Embalmer No. 2986

P. O. Address St Joseph, 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.**