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17-39
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FILED MAY 27 1948

Registration District No. 1

Primary Registration District No. 3000 500 6

Registrar's No. 129

1. PLACE OF DEATH:

(a) County Schuyler Adair
(b) City or town Downing (Rural)
(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 Mo (b) County Schuyler 78
(c) City or town Downing Rural
(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 Isaac Cooper

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Grace Cooper 6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Aug 6 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 8 Days 9 If less than one day hr. _____ min. _____

9. Birthplace: Hancock Ill (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Polk Cooper 9
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Sarah Blage
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Grace Cooper
(b) Address Willmuthville Mo

17. (a) Burial (b) Date thereof April 18 1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation pleasant Hill

18. (a) Signature of funeral director Loyle Inoue
(b) Address 19 Downing Mo

19. (a) 7-18-46 (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 15th
year 1946 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from April 15
1946 to April 15 1946
that I last saw him alive on April 15 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 3 day

Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations lob
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 2
23. Signature E. E. Symmonds (M. D. or other) do
Address Memphis Mo Date signed April 16 1946

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

RECEIVED
District Health Officer No. 10
District File Number 5-46-10
Date Filed MAY-23-1946

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 Jne

....., Registered Apprentice No.
working under my personal supervision.

Signed Loyd Moore
Licensed Embalmer No. 2151
P. O. Address Dorwig m

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. June

Registration District No. _____

Primary Registration District No. 5006

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Rural Park Twp
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
SE of Brenton Mo
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution in ways hosp
 (Specify whether
 In this community _____
 years, months or days) X

3. (a) PRINT
FULL NAMEIsaac Cooper3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex m 5. Color or
race w 6. (a) Single, widowed, married,
divorced m6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased _____
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
70 hr. _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Kate Lambert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County (Scotland)
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. Dawning -Rural
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year 1946 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Requested Information

135917

W. B. Jones
Co.