No. 2
-2-43
17-39
X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 7 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 23336

Registration District No. 127 Primary Registration District No. 5464 Registrar's No. 7

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Willard
(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
X In this community 3 mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

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

(d) Street No. 6
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) /

If yes, name country

3. (a) PRINT FULL NAME William C. Cooper

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married, divorced 2 widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased March, 4, 1862
(Month) (Day) (Year)

8. AGE: Years 84 Months 4 Days 5 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown 0
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. D.L. Word
(b) Address Willard, Mo.

17. (a) burial (b) Date thereof July, 11, 46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Wise Hill cem.

18. (a) Signature of funeral director T.W. Maples
(b) Address Clever, Mo.

19. (a) July 20 '46 (b) Jane Appleby
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9th
year 1946 hour 7 minute P M.

21. I hereby certify that I attended the deceased from June 23, 1946 to July 9, 1946
that I last saw him alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Insufficiency — Duration 2 mo

Due to Chr degenerative cardio vasc. renal disease — yrs

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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Arthur D. Maple M.D. (M. D. or other)
Address 450 1/2 E. Court St. Date signed 7-13-46

110

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Greene County Health Office,
County File Number 46-8-94
Date Filed 8-5-46

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, XXX

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. W. Maples

Licensed Embalmer No. 2985

P. O. Address Clever, 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.

No. 2B
—3-45
P I X43880

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. Aug

Registration District No. 127 Primary Registration District No. 546 A Registrar's No. 7

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Willard
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME William C. 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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Mar. 4 1864 (Month) (Day) (Year)
8. AGE: Years 84 Months 4 Days Unless than one day hr. min.
9. Birthplace (City, town, or county) Tenn (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) Jane Appleby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 9 year 1946 hour minute M.
21. I hereby certify that I attended the deceased from , 19 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

23336