

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34748**
Registrar's No. **2096**

Registration District No. **317** Primary Registration District No. **6076**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Ridge wood Hills**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
619 Bells worth Dr. /
(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 **St. Louis 9/6**
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. **619 Bells worth Dr.** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William A.P. Cooper**
3. (b) If veteran, name war **no.** 3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Oct.** day **7**
year **1946** hour **8** minute **15 A.M.**
21. I hereby certify that I attended the deceased from **Apr 28, 1943** to **Oct 7, 1946**
that I last saw him alive on **Oct 7, 1946**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **widower**
6. (b) Name of husband or wife **Mattie J. Cooper** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Nov. 15 1854**
(Month) (Day) (Year)

Immediate cause of death
Chronic Myocardial 5 yrs
Chronic Nephritis
Due to _____
Due to **1315**
Other conditions (Include pregnancy within 3 months of death) _____

8. AGE: Years Months Days If less than one day
91 10 22 hr. _____ min.

9. Birthplace **Clover Bottom Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Receiving Manager Retiree**

11. Industry or business
12. Name **Robert Cooper**
13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah Herritt**
15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Virginia Lawmayer**
(b) Address **619 Bells worth Dr.**

17. (a) **Burial** (b) Date thereof **10-10-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Dixon Mo.**

18. (a) Signature of funeral director **Witt Bro. & Co.**
(b) Address **2929 S. Jefferson Av.**

19. (a) **10-10-46** (b) **Ruth Calender**
(Date received local registrar) (Registrar's signature)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
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 **2**
23. Signature **J. G. White** (M. D. or D.O.)
Address **6765 W. Vermont** Date signed **Oct 8-46**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
33569

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..... *Harold C. Witt*

Licensed Embalmer No. *4353*

P. O. Address. *2929 S. Jefferson Ave*

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.