

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8506**
Registrar's No. **7**

FILED MAR 21 1947
Registration District No. **099**

Primary Registration District No. **5424**

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

1. PLACE OF DEATH:

(a) County Dunklin
 (b) City or town Sibson
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: None
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: — (Specify whether
 In this community life years, months or days)

3. (a) PRINT FULL NAME James Walker Cooper
 3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex male 5. Color or race white
 6. (a) Single, widowed, married, divorced, Infant
 6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased: February 25 1947
 (Month) (Day) (Year)

8. AGE: Years ~ Months Days If less than one day
2 hr. min.

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

10. Usual occupation —

MOTHER FATHER

11. Industry or business —

12. Name James M. Cooper
 13. Birthplace Georgia
 (City, town, or county) (State or foreign country)

14. Maiden name Louise Williams
 15. Birthplace Sibson Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant James M. Cooper
 (b) Address Sibson, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-28-47
 (Month) (Day) (Year)
 (c) Place: burial or cremation Stanfield

18. (a) Signature of funeral director Landers Funeral Home
 (b) Address Campbell, Missouri

19. (a) — (Date received local registrar)
 (b) Mrs. Beulah Campbell (Registrar's signature)
 (c) Campbell, Mo (Address) Date signed 3/1/47

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dunklin
 (c) City or town Sibson
 (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 —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27
 year 1947 hour — minute 10:00AM

21. I hereby certify that I attended the deceased from 2/25 1947 to 2/27 1947
 that I last saw him alive on 2/27 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death: Strangulation (mucosa)
 Due to —
 Due to —

Other conditions: —
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations —
 Of autopsy 161A

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? —

Signature — (Specify type of place)
 Means of injury —
 Date signed 3/1/47

Duration —

PHYSICIAN —

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 34-263

Date Filed 3-12-42

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.

Not Embalmed

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.