No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 30 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 22143

Registrar's No. 6033

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10-days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3839 Greer Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME William J. 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 M.
6. (b) Name of husband or wife Vivian Cooper
6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased Oct. 28th., 1891 (Month) (Day) (Year)

8. AGE: Years 55 Months 7 Days 23 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Health Inspector
11. Industry or business

MOTHER FATHER
12. Name William Cooper
13. Birthplace New York (City, town, or county) (State or foreign country)
14. Maiden name Mary Walsh
15. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Mrs. Vivian M. Cooper
(b) Address 3839 Greer Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-24-47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.
19. (a) JUN 23 1947 (Date received local registrar) (b) J. F. Breen (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 21st., year 1947 hour 9 minute 45 a. M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.
Immediate cause of death Surgical Shock Duration
Due to Cardiac Weakness Duration
Due to Bronchopneumonia Duration
Due to June 21st 1947 about 9:45 a.m.
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 Means of injury

23. Signature Alfred Parks (M. D. or other)
Address Date signed 6/23/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.