

S. No. 2
M-8-43
5-17-39
I X37823

1908

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JAN 24 1948

Registration District No. 251

Primary Registration District No. 3048

Registrar's No. 10

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

1. PLACE OF DEATH:
 (a) County NOBIAWAY
 (b) City or town MARYVILLE MO.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
ST. FRANCIS HOSP. O
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution one day
(Specify whether)
 In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State KANSAS (b) County 999
 (c) City or town ATCHISON 14
(If outside city or town limits, write "RURAL")
 (d) Street No. 425 LARAMIE 0
(If rural, give location)
 (e) Citizen of foreign country? NO (Yes or No) 2
 If yes, name country _____

3. (a) PRINT FULL NAME CLARENCE BERNARD COOPER
 3. (b) If veteran; name war NO
 3. (c) Social Security No. 491-09-7506

20. DATE OF DEATH: Month 1 day 7
 year 1948 hour 5 minute 20 A. M.

MEDICAL CERTIFICATION

4. Sex MALE 5. Color or race W
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife LILLIAN AGNES COOPER
 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 1-6
1948 to 1/7 1948
 that I last saw him alive on 1/7 1948
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>32</u>	<u>8</u>	<u>9</u>	hr. _____ min. _____

Immediate cause of death
Compensated comminuted fracture of skull with
Due to gunshot laceration
of forehead
Due to perforating wound
of buttocks 18 hrs.
 Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace ST JOSEPH MISSOURI
(City, town, or county) (State or foreign country)
 10. Usual occupation ELEVATOR CONSTRUCTION

Major findings: as above
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business OTIS ELEVATOR
 12. Name CHARLES C. COOPER
 13. Birthplace RUSHVILLE MISSOURI
(City, town, or county) (State or foreign country)
 14. Maiden name ANNA PEARL JESSEN
 15. Birthplace CHICAGO ILLS.
(City, town, or county) (State or foreign country)

16. (a) Informant CHARLES C. COOPER
 (b) Address ST. JOSEPH MO
 17. (a) BURIAL (b) Date thereof 1 10 48
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation ST JOSEPH MO.
 18. (a) Signature of funeral director Victor Barry
 (b) Address 2248 So 19 St JOSEPH MO
 19. (a) 1-8-48 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) accidents
 (b) Date of occurrence 1/6/48
 (c) Where did injury occur? Manynett's Machine 14
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
new new building
(Specify type of place)
 While at work? yes (e) Means of injury falling
 23. Signature W. D. DeWard (M. D. or other) MD
 Address Manynett Mo. Date signed 1/7/48

NOV 9 1948

NOV 28 1948

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 Victor Barry

Licensed Embalmer No. 4212

P. O. Address St Joseph 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.