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1/47  
17-39

FILED JUL 3 1948 318  
National Office of Vital Statistics

Registration District No.

Primary Registration District No.

1003

Registrar's No.

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: Homer C. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 17 Hrs. 35 Mins.  
(Specify whether  
In this community  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL.") 17  
(d) Street No. 1700 Biddle  
(If rural, give location) 9  
(e) Citizen of foreign country?..... (Yes or No) 0  
If yes, name country.....

3. (a) PRINT FULL NAME

Marie Cooper

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

4. Sex Female  
3

5. Color or race Negro

6. (a) Single, widowed, married, divorced..... 0

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive..... years 48

7. Birth date of deceased.....  
(Month) 5 (Day) 27 (Year) 48

8. AGE:

Years Months Days If less than one day  
17 hr. 35 min.

9. Birthplace.....  
(City, town, or county) St. Louis

(State or foreign country) Missouri

10. Usual occupation.....

11. Industry or business.....

12. Name..... Robert Cooper

13. Birthplace.....  
(City, town, or county) New Madrid (State or foreign country) Missouri

14. Maiden name..... Marie Johnson

15. Birthplace.....  
(City, town, or county) Greenville (State or foreign country) Mississippi

16. (a) Informant Arthur M. Sherard, M.D.  
(b) Address 2601 N. Whittier

17. (a) Anatomical Board (b) Date thereof JUN 30 1948  
(Burial, cremation, or other disposition) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Rowland Mortuary Service

(b) Address 4104 Manchester Ave.

19. (a) JUN 30 1948 (b) J. F. Breach  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 28  
year 1948 hour 8:45 minute A. M.

21. I hereby certify that I attended the deceased from 3:10 P. M.  
5-27-48 19... to 8:45 A.M. 5-28 19...  
that I last saw her alive on 5-28 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Prematurity

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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 W. L. Lumber (M. D. XXXX)

Address 2601 N. Whittier Date signed 6-10-48

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

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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.....

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.