

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43352

State File No. \_\_\_\_\_

FILED DEC 22 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 6092 Registrar's No. 228

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Malta Bend (Rural)</b> ) c. LENGTH OF STAY (In this place) <b>2 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Malta Bend (Rural) Grand Pass</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2 Mi. N.E. Grand Pass, Mo.</b>		d. STREET ADDRESS (If rural, give location) <b>2 Mi. N.E. of Grand Pass, Mo.</b>	
3. NAME OF DECEASED a. (First) <b>MARY</b> b. (Middle) <b>EFFIE</b> c. (Last) <b>COOPER</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 14, 1949</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>March 5, 1898</b>
9. AGE (In years last birthday) <b>51</b>		IF UNDER 1 YEAR Months Days	IF UNDER 2 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri D</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>William Eli Jordan</b>	
13b. MOTHER'S MAIDEN NAME <b>Elizabeth Swan</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Raymond Wesley Cooper Malta Bend, Mo</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiovascular Renal Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 mo</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>442X</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12-14<sup>th</sup></b> , 19 <b>49</b> , to <b>12-14</b> , 19 <b>49</b> that I last saw the deceased alive on <b>12-14</b> , 19 <b>49</b> , and that death occurred at <b>1:20 P</b> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Geo A. Kelling MD</b>		23b. ADDRESS <b>Waverly Mo</b>	
23c. DATE SIGNED <b>12-15-49</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24b. DATE <b>Dec. 16, 1949</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Grand Pass Com. Cem</b>		24d. LOCATION (City, town, or county) (State) <b>Grand Pass, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>Dec. 16-1949</b>		REGISTRAR'S SIGNATURE <b>Edw. J. Goody</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry Hershberg</b>		ADDRESS <b>Marshall, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED BALDWIN 1950  
DEC 19

District Health Officer No. 8,  
District File Number

Filed 12-21-49

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

Student Embalmer No.

working under my personal supervision.

Student Student Embalmer

Signed Joseph R. Madala  
Licensed Embalmer No. 4571

P. O. Address Marshall, 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.