

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3901**
Registrar's No. **221**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000**

1. PLACE OF DEATH a. COUNTY BUCHANNAN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Holt	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. JOSEPH		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Oregon (Rural)	
c. LENGTH OF STAY (In this place) 2 hours		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION GENERAL OSTEOPATHIC			

3. NAME OF DECEASED (Type or Print)	a. (First) DAVID	b. (Middle)	c. (Last) COOPER	4. DATE OF DEATH (Month) (Day) (Year) FEB. 26 1950
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 23 1881	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) 4 UBOYNE, ABERDEENSHIRE SCOTLAND	12. CITIZEN OF WHAT COUNTRY BRITISH
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13a. FATHER'S NAME DAVID COOPER	13b. MOTHER'S MAIDEN NAME ELIZABETH ARCHIBALD	14. NAME OF HUSBAND OR WIFE IRENE RAMSAY COOPER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. NO.	17. INFORMANT'S SIGNATURE OR NAME IRENE COOPER ADDRESS OREGON, MO.
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PERFORATED GASTRIC ULCER		INTERVAL BETWEEN ONSET AND DEATH 7 Hours
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		5401
	DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. PROSTATIC HYPERTROPHY		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from June, 1949, to Feb 26, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 10 A. M., from the causes and on the date stated above.

23a. SIGNATURE H. E. Carkin D.O. (Degree or title)	23b. ADDRESS Oregon Mo.	23c. DATE SIGNED Feb. 28 50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-1-50	24c. NAME OF CEMETERY OR CREMATORY Maple Grove	24d. LOCATION (City, town, or county) (State) Oregon Mo.
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DATE REC'D BY LOCAL REG. Feb. 27, 1950	REGISTRAR'S SIGNATURE H. E. Carkin	25. FUNERAL DIRECTOR'S SIGNATURE James Pettigrew ADDRESS Oregon Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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MAR 14 1936

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 _____

James H. Crawford, Student Embalmer No. 352
working under my personal supervision.

Student James H. Crawford
Student Embalmer

Signed J. H. Crawford
Licensed Embalmer No. 1824

P. O. Address Mound City, 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.