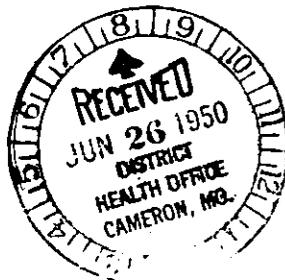


FILED AUG 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24073

BIRTH NO.		REG. DIST. NO. 210		PRIMARY REG. DIST. NO. 5772		Registrar's No. 39	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)			
a. COUNTY MERCER		b. CITY (If outside corporate limits, write RURAL and give township) HALF ROCK		a. STATE MO		b. COUNTY MERCER	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) HALF ROCK		d. STREET ADDRESS 1		OR TOWN 1650	
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX	
a. (First) JOHN	b. (Middle) L	c. (Last) COOPER	Month JUNE	Day 9	Year 1950	0	MALE
6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH OCT-23-1861		9. AGE (In years last birthday) 88	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GENERAL STORE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME SQUIRE COOPER			13b. MOTHER'S MAIDEN NAME UNKNOWN			14. NAME OF HUSBAND OR WIFE JOSIE COOPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME JOSIE COOPER Half Rock Mo.			
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) Carcinoma of prostate  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.				INTERVAL BETWEEN ONSET AND DEATH 3 mo  177X	
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)		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 8/1/50, 1950, to 6/9, 1950, that I last saw the deceased alive on 6-8, 1950, and that death occurred at 11:45 p.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) W. W. Harris, Jr.				23b. ADDRESS Harris Mo		23c. DATE SIGNED 6/1/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JUNE-11-50		24c. NAME OF CEMETERY OR CREMATORY HALF ROCK CEM.		24d. LOCATION (City, town, or county) (State) HALF ROCK MO	
DATE REC'D BY LOCAL REG. 6-20-50		REGISTRAR'S SIGNATURE M. J. Ruff		25. FUNERAL DIRECTOR'S SIGNATURE Schools funeral Home Spickard 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.....

Student Embalmer No. ....

working under my personal supervision.

Signed.....

*Ross Wise*

Signed.....

Student Embalmer

Licensed Embalmer No. *3771*

P. O. Address *Spickard 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.