S. No. 300
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FILED SEP 1 1950

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 28845

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 2013

1. PLACE OF DEATH
a. COUNTY: St Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Louis County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Mo
b. COUNTY: St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 62 Webster Grove 4627
d. STREET ADDRESS (If rural, give location): 900 Ennis

3. NAME OF DECEASED (Type or Print)
a. (First): Patsy
b. (Middle): —
c. (Last): Cooper

4. DATE OF DEATH (Month) (Day) (Year): 8 19 1950

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: ? 1865
9. AGE (In years last birthday): 85 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Ark
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: unknown
13b. MOTHER'S MAIDEN NAME: unknown
14. NAME OF HUSBAND OR WIFE: Aaron Cooper - Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT'S SIGNATURE OR NAME: Susie Reeves ADDRESS: 900 Ennis

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident

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: 331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 334X
20. AUTOPSY? YES ☐ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19 2 P.m. 1950, *to* 8-19, 1950 3:20 P.m., *that I last saw the deceased alive on* 8-19-, 1950, *and that death occurred at* 3:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur E Schmidt (Degree or title) MD
23b. ADDRESS: 601 S. Brentwood Blvd.
23c. DATE SIGNED: 8-19-1950.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/23/50
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St Louis County

DATE REC'D BY LOCAL REG.: 8-22-50
REGISTRAR'S SIGNATURE: Herbert R Domke, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE: Susie C Lewis ADDRESS: 22 Euclid W.G.

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed A D Richardson

Signed.....
Student Embalmer

Licensed Embalmer No. 2928

P. O. Address 2615 Glasgow

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.