

FILED OCT 10 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29398**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **249**

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

1. PLACE OF DEATH a. COUNTY <b>Boone</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Cole</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Columbia</b>		c. CITY (If outside corporate limits; write RURAL and give township) <b>Jefferson City</b> <b>0261</b>	
c. LENGTH OF STAY (in this place) <b>10 days</b>		d. STREET ADDRESS (If rural, give location) <b>310 Jackson St.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Noves Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>John W. Cooper</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 3, 1950</b>		
a. (First)		b. (Middle)		c. (Last)	

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 25 1873</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>3</b>	IF UNDER 24 HRS. Days <b>8</b>	IF UNDER 1 HRS. Hours <b></b>	IF UNDER 15 MIN. Min. <b></b>
-----------------------	----------------------------------	--	---	--	---------------------------------------	--------------------------------------	-------------------------------------	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
---	--	---	--	--	--	--	--

13a. FATHER'S NAME <b>Thomas P. Cooper</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Quely</b>		14. NAME OF HUSBAND OR WIFE <b>Susan L. Cooper</b>	
---	--	---	--	---	--

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>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Susan L. Cooper</b>		ADDRESS <b>Jefferson City, 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Bladder</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</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>18.1X</b>	

19a. DATE OF OPERATION <b>Sept 5 50</b>		19b. MAJOR FINDINGS OF OPERATION <b>As above</b>		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 **Sept 5, 1950**, to **Oct 4, 1950** that I last saw the deceased alive on **Oct 3, 1950**, and that death occurred at **10:30 pm.**, from the causes and on the date stated above.

23a. SIGNATURE <b>James C. Cooper MD</b>		(Degree or title)		23b. ADDRESS <b>Columbia, Mo. 909 University</b>		23c. DATE SIGNED <b>Oct 5 50</b>	
---	--	-------------------	--	---	--	-------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Oct. 5, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Jefferson City, Mo.</b>	
--	--	----------------------------------	--	---	--	---	--

DATE REC'D BY LOCAL REG. <b>Oct 6 1950</b>		REGISTRAR'S SIGNATURE <b>Mrs R E Palmer</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Victor Buesche</b>		ADDRESS <b>Jefferson City Mo</b>	
---	--	--	--	---	--	-------------------------------------	--

RECEIVED 10-9-50

DISTRICT HEALTH OFFICE No. 3

District File Number \_\_\_\_\_

Date Filed 10-9-50

OCT 10 1950

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 Victor Buescher

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3701

P. O. Address Jefferson 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.