

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38190

State File No.

BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 6009 Registrar's No. 76

0930

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

| | | | |
|---------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Clair</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u> | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Collins (Rural)</u>) | | c. CITY (If outside corporate limits, write RURAL and give township) <u>0381</u> OR TOWN <u>Albany</u> | |
| c. LENGTH OF STAY (In this place) <u>2 1/2</u> years | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Washington Township</u> | | | |

| | | | | | |
|--------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|------------------------------------------------------------|------------------------------------------------------------------------|--|
| 3. NAME OF DECEASED a. (First) <u>Whitney</u> b. (Middle) <u>Logan</u> c. (Last) <u>Cooper</u> | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>11-18-1950</u> | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, OR FORCED (Specify) <u>MARRIED</u> | |
| 8. DATE OF BIRTH <u>12/12/1883</u> | | 9. AGE (In years) (Month) (Day) (Hour) (Min.) <u>66</u> | | 10. KIND OF BUSINESS OR INDUSTRY <u>Building</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 13a. FATHER'S NAME <u>Coleman Cooper</u> | | 13b. MOTHER'S MAIDEN NAME <u>Josephine Logan</u> | | 14. NAME OF HUSBAND OR WIFE <u>Irene Cooper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. _____ | | 17. INFORMANT'S SIGNATURE OR NAME <u>Merle Smith</u> ADDRESS <u>Maryville Mo.</u> | |

| | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|-------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gun Shot Wound</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>E981X</u> |
| | | 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. | | | | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

| | | | | | |
|-----------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Homicide</u> | | 21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <u>In Home</u> | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Collins, Washington St. Clair Mo.</u> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>11-18-1950-11P</u> | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <u>Gun fired by Irene Cooper</u> | |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:00 m., from the causes and on the date stated above.

| | | | | | |
|-------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|-----------------------------------------------------|--|
| 23a. SIGNATURE (Degree or title) <u>Fairfax B. Goodrich, Coroner</u> | | 23b. ADDRESS <u>Osceola Missouri</u> | | 23c. DATE SIGNED <u>11/22/50</u> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>11/24/50</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>Albany</u> | |
| | | 24d. LOCATION (City, town, or county) (State) <u>Albany Missouri</u> | | | |

| | | | | | |
|------------------------------------------|--|-----------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| DATE REC'D BY LOCAL REG. <u>11-23-50</u> | | REGISTRAR'S SIGNATURE <u>Frank Seewers</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>F B Goodrich</u> ADDRESS <u>Osceola Mo</u> | |
|------------------------------------------|--|-----------------------------------------------|--|--------------------------------------------------------------------------------------|--|

RECEIVED 12/7/50

DISTRICT HEALTH OFFICE No. 3

District File Number

Date Filed 12/7/50

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 J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Osceola, 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.