V. S. No. 300
Rev. 10-48

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38374

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9372

1. PLACE OF DEATH
a. COUNTY -
b. CITY OR TOWN: ST. LOUIS
c. LENGTH OF STAY (in this place): 42 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jewish Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: " "
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2069
d. STREET ADDRESS (If rural, give location): 1343 Goodfellow 0

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

4. DATE OF DEATH (Month) (Day) (Year): 11 4 50

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 16 1908
9. AGE (In years last birthday): 42
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): Grocer
10b. KIND OF BUSINESS OR INDUSTRY: Retail Store
11. BIRTHPLACE (State or foreign country): St. Louis Mo
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: Manuel Cooper
13b. MOTHER'S MAIDEN NAME: Ada Darnell
14. NAME OF HUSBAND OR WIFE: Eva

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.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Mrs Eva Cooper 1343 Goodfellow

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) Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Adenocarcinoma of — 5 month

DUE TO (c) pancreas

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 ☐ 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? 157 X

22. *I hereby certify that I attended the deceased from* October 1, 1950, *to* November 5, 1950, *that I last saw the deceased alive on* 11-3-50, 19____, *and that death occurred at* 5:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Catherine Jean Crawford MD
23b. ADDRESS: Jewish Hosp of St Louis
23c. DATE SIGNED: 11-5-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 11/5/50
24c. NAME OF CEMETERY OR CREMATORY: Jefferson Barracks
24d. LOCATION (City, town, or county) (State): Unknown Mo

DATE REC'D BY LOCAL REG.: NOV 5 1950
REGISTRAR'S SIGNATURE: G. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Berger Memorial 4115 McPherson

(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 .....

..... Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed [signature]

Licensed Embalmer No. [illegible]

P. O. Address .....

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.