

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 7 1951

State File No. 29044

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 3009

1. PLACE OF DEATH a. COUNTY <u>St. Louis County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>Kinloch</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>Kinloch</u>	
c. LENGTH OF STAY (In this place) <u>Blanche</u>		d. STREET ADDRESS (If rural, give location) <u>1020 Bay St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1020 Bay St.</u>		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: <u>4091</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Dora</u>	b. (Middle)	c. (Last) <u>Cooper</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>8</u> <u>26</u> <u>1951</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1891?</u>	9. AGE (In years last birthday) <u>70?</u>	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>X</u>	11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>?</u>	13b. MOTHER'S MAIDEN NAME <u>?</u>	14. NAME OF HUSBAND OR WIFE <u>Agnes Cooper</u>
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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. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Columbus Buchanan 1020 Bay St.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>X</u> DUE TO (c) <u>332X</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>X</u>			

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>Kinloch, St. Louis, Mo.</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 Aug 10, 1951, to Aug 25, 1951, that I last saw the deceased alive on Aug 25, 1951, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Chas. P. Fonde, M.D.</u>	23b. ADDRESS <u>2702 A Franklin</u>	23c. DATE SIGNED <u>8/26/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 30 1951</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8-29-51</u>	REGISTRAR'S SIGNATURE <u>Robert P. Fonde M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>English Und. Co. 2931 Lucas</u>
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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 *A. Richardson*

Licensed Embalmer No. *2928*

P. O. Address. *2625 Glasgow*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.