

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44138**
Registrar's No. **11961**

FILED JAN 5 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		e. STREET ADDRESS (If rural, give location) 618 S. Garrison	

3. NAME OF DECEASED (Type or Print)	a. (First) Henry	b. (Middle)	c. (Last) Cooper	4. DATE OF DEATH (Month) (Day) (Year) 12 14 53
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5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 12/25/1884	9. AGE (In years less birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 1 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Alabama	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME George Cooper	13b. MOTHER'S MAIDEN NAME Emma O'Neal	14. NAME OF HUSBAND OR WIFE ?
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Bessie Hamer, Sister ADDRESS 618 S. Garrison
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Far advanced pulmonary tuberculosis		INTERVAL BETWEEN ONSET AND DEATH Unit 8.
	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 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X
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22. I hereby certify that I attended the deceased from **12/5/1953**, to **12/14/1953**, that I last saw the deceased alive on **12/14/1953**, and that death occurred at **9:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE E. B. Williams (Degree or title) M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 12/15/53
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24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE Dec 21/53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis Co., MO
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DATE REC'D BY LOCAL HEALTH DEPT. DEC 19 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Fred Green ADDRESS 4714 Selman
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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.....
Signature of Student Embalmer

Signed.....
F. A. Gean

Licensed Embalmer No. *2963*

P. O. Address *4314 Panama*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.