

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

826

State File No.

BIRTH NO. FILED FEB 9 1954 REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5430 Registrar's No.

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Rural. Central</i>		c. CITY OR TOWN <i>Rural</i> <i>0360</i> d. IS RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Zane Hill - R #1</i>		e. STREET ADDRESS (If rural, give location) <i>Zane Hill - Mo R #1</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>William</i> b. (Middle) <i>Walter</i> c. (Last) <i>Cooper</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>2 - 2 - 1954</i>		
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5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>12-16-1876</i>	9. AGE (In years last birthday) <i>78</i>	IF UNDER 1 YEAR Months <i>1</i> Days <i>19</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>farming</i>		11. BIRTHPLACE (City and State or Foreign Country) <i>Franklin Co. Mo</i>		12. CITIZENSHIP OF WHAT COUNTRY? <i>U.S.A.</i>	
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13a. FATHER'S NAME <i>Walter Cooper</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Duncan</i>		14. NAME OF HUSBAND OR WIFE <i>Alice</i>	
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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) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Dorrie Motherhead</i>		ADDRESS <i>Sullivan</i>	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Sullivan</i> ANTECEDENT CAUSES <i>Acute Status Asthmaticus</i> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> <i>Chronic Pulmonary Emphysema</i> II. OTHER SIGNIFICANT CONDITIONS <i>Chronic Purulent Bronchitis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Respiratory</i> <i>7 years</i>	
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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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from *Oct 53*, to *2-2-54*, that I last saw the deceased alive on *1-30-1954* and that death occurred at *8:45* m., from the causes and on the date stated above.

23a. SIGNATURE <i>W. E. Mitchell M.D.</i> (Degree or title)		23b. ADDRESS <i>St. Clair - Mo</i>		23c. DATE SIGNED <i>2-3-54</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24b. DATE <i>2-3-54</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Hospice Cemetery Franklin Co. Mo</i>		24d. LOCATION (City, town, or county) (State) <i>Franklin Co. Mo</i>	
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DATE REC'D BY LOCAL REG. <i>2-3-54</i>		REGISTRAR'S SIGNATURE <i>William Cooper</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Shirley Mitchell</i>		ADDRESS <i>St. Clair, Mo.</i>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 17 1954

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: *Sherrill W. Ketchel*

Licensed Embalmer No. 38

P. O. Address *H. Clark*

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.