

No. 300  
10. 28  
2018

FILED MAY 12 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14313**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **531** Registrar's No. **948**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b> Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>University City</b>		c. CITY OR TOWN <b>University City 33</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6933 Kingsbury</b>		e. STREET ADDRESS (If rural, give location) <b>6933 Kingsbury Blvd</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Marynie</b> b. (Middle) <b>Virginia</b> c. (Last) <b>Cooper</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 21, 1954</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 14, 1878</b>
9. AGE (In years last birthday) <b>75</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Bluff Springs Fla.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Unknown</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>James F. Cooper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>288-22-8445</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Virginia Bayer</b>		ADDRESS <b>6933 Kingsbury Pl.</b>	

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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Pseudo bulbar Paralysis</b> <b>1 yr</b> DUE TO (c) <b>Arteriosclerosis Generalis Arterial</b> <b>?</b> 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"/>

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) <b>4500</b>
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?

22. I hereby certify that I attended the deceased from **July 19, 1954** to **April 21, 1954** that I last saw the deceased alive on **April 18, 1954**, and that death occurred at **9:00 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Lee N. Wagness M.D.</b>	23b. ADDRESS <b>University City, Mo</b>	23c. DATE SIGNED <b>April 22, 1954</b>
24a. BURIAL / CREMATION / INTERMENT (Specify) <b>Burial</b>	24b. DATE <b>April 23, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>		

DATE REC'D BY LOCAL REG. <b>5/12/54</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Ambrose</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Alexander &amp; Sons</b>	ADDRESS <b>6175 Delmar Blv</b>
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(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.....  
Signature of Student Embalmer

Signed *Jos. E. McCulloch*.....

Licensed Embalmer No. *246*.....

P. O. Address *6175 9th*.....

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.