

FILED SEP 7 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **27160**  
**3962**

BIRTH NO. _____		REG. DIST. NO. <b>149</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. LENGTH OF STAY (in this place) <b>35-40</b>		c. CITY OR TOWN <b>KANSAS CITY</b>		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 <b>ST. LUKE'S HOSPITAL</b>				f. STREET ADDRESS (If rural, give location) <b>THE WALNUTS 3726 5049 WORNALL ROAD 0</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>BESS</b> b. (Middle) <b>I.</b> c. (Last) <b>COOPER</b>			4. DATE OF DEATH <b>AUGUST-14-1954</b>						
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE-1-1878</b>	9. AGE (In years last birthday) <b>76</b>	if UNDER 1 YEAR Months _____ Days _____	if UNDER 2 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>HAMILTON ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>JOSEPH W. POWERS</b>		13b. MOTHER'S MAIDEN NAME <b>Blancha FORNEY</b>		14. NAME OF HUSBAND OR WIFE <b>DR. J. H. 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>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>DR. J. H. COOPER</b> ADDRESS <b>5049 WORNALL ROAD KANSAS CITY MO.</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 days.</b>	
				* ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterial Hypertension</b> <b>48 mos.</b> DUE TO (c) <b>Arteriosclerosis, Generalized</b> <b>4 years</b>					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>331X</b>					
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) _____					
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 <b>August 5, 1954</b> , to <b>August 14, 1954</b> , that I last saw the deceased alive on <b>8/14</b> , 1954, and that death occurred at <b>7:55A</b> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>Arnold V. Arms</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>463 W. Lyandotte Kansas City Mo.</b>		23c. DATE SIGNED <b>8/14/54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>AUG-16-1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>			
DATE REC'D BY LOCAL REG. <b>8-16-54</b>		REGISTRAR'S SIGNATURE <b>Geraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>O.W. Neocomer's Sons</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY MO.</b>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.....  
Signature of Student Embalmer

Signed *Basil Honey*.....

Licensed Embalmer No. *47*

P. O. Address *K.C.*

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.