

No. 300  
10.48

FILED SEP 4 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26539

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 785

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	c. LENGTH OF STAY (in this place) <u>9 yrs.</u>	c. CITY OR TOWN <u>Springfield</u>	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 <u>St. Johns Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>312 E. Locust</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) _____ c. (Last) <u>COOPER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1956</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 20, 1882</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>In Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>John T. Pace</u>		13b. MOTHER'S MAIDEN NAME <u>Bird</u>		14. NAME OF HUSBAND OR WIFE <u>Wm. A. Cooper</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Wm. A. Cooper Springfield, Missouri</u>			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart failure</u>	DUE TO (b) <u>Aortic Valvular Stenosis</u>			<u>1 yr.</u>
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (c) _____			<u>Unknown</u>
II. OTHER SIGNIFICANT CONDITIONS	<u>Multiple Pulmonary infarctions</u>			<u>1 wk.</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>Springfield Greene Mo.</u>		
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
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22. I hereby certify that I attended the deceased from Feb 20, 1956, to Aug 29, 1956, that I last saw the deceased alive on Aug 29, 1956, and that death occurred at 1:05 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>D. D. Hilkey M.D.</u>		23b. ADDRESS <u>609 Cherry St.</u>	23c. DATE SIGNED <u>Aug 30 56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>8-30-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SPOKANE CEMETERY, SPOKANE, MO.</u>	24d. LOCATION (City, town, or county) (State) _____
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DATE REC'D BY LOCAL REG. <u>8-31-56</u>	REGISTRAR'S SIGNATURE <u>Edith Williams</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. N. Klingner Springfield, Missouri</u>	
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(Licensed Embalmer) Statement on Reverse Side

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

SEP 27 1956

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 *Max Rhodes*.....

Licensed Embalmer No. *407*

P. O. Address *Spring*.....

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.