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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 15 1957

STATE FILE NUMBER 10094

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3131

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits; give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in Ib: 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 1217 N. Compton — Reside on Farm: Yes ☐ No ☐

27 2/19

3. NAME OF DECEASED (Type or print): First: Ben — Middle: — Last: Cooper

4. DATE OF DEATH: Month 3 — Day 27 — Year 57

5. SEX: Male 2

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept 3, 1878

9. AGE (In years last birthday): 78

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): Ala.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Cooper

14. MOTHER'S MAIDEN NAME: Emma ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Della Cooper — Address: 1175. Compton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Decubitus Ulcers of Buttocks, Back and Legs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ **SUICIDE** ☐ **HOMICIDE** ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 1-23-57, to 3-27-57 and last saw ~~him~~ him alive on 3-27-57
Death occurred at 2:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Frank O. Richards (Degree or title): M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 3-28-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: April 2/57

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cem

23d. LOCATION (City, town, or county): St Louis (State): Mo

24. FUNERAL DIRECTOR: T. A. Green — **ADDRESS**: 4214 Delmar

25. DATE RECD. BY LOCAL REG.: APR 1 '57

26. REGISTRAR'S SIGNATURE: J. Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

1956
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78

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed F. G. Green

Licensed Embalmer No. 296

P. O. Address 4214 Delmar

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.