

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33105  
STATE FILE NUMBER  
Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 52

FILED OCT 2 1957

300  
1-57/

1. PLACE OF DEATH a. COUNTY <b>St; Clair</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Clair</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Osceola</b>		c. CITY OR TOWN <b>Osceola</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location): HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <b>50 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert L. Cooper</b>			4. DATE OF DEATH Month Day Year <b>Sept; 13. 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1872</b>
9. AGE (In years last birthday) <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and Stockman</b>	
11. BIRTHPLACE (City and state or country) <b>St; Clair County Mo;</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Madison L. Cooper</b>		13b. MOTHER'S MAIDEN NAME <b>Lucy Estes</b>	
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <b>Unknown</b> ) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Herbert Cooper, Osceola Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>HYPERTENSION</b>			<b>UNKNOWN</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) <b>331X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <b>9-8-57</b> to <b>9-13-57</b> and last saw him alive on <b>9-13-57</b> Death occurred at <b>4:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>A. L. Shipman</b> (Name or title)		22b. ADDRESS <b>Osceola Missouri</b>	22c. DATE SIGNED <b>9/14/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/16/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Osceola</b>	23d. LOCATION (City, town, or county) (State) <b>Osceola Missouri</b>
24. FUNERAL DIRECTOR <b>Goodrich 2-HOME OSCOLA MO</b>		25. DATE RECD. BY LOCAL REG. <b>9-14-1957</b>	26. REGISTRAR'S SIGNATURE <b>Paul S. Sewers</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Occasion, manner, enter most important statements concerning the death. No symptoms will be entered. All diseases in Part I must be causally related.

OCT 18 1957

*Handwritten scribbles*

**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 *J.B. Bradish* .....

*72-81-P*

*72-81-P*

Licensed Embalmer No. *3038*

P. O. Address *Quincy*

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.