

FILED MAY 29 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-018946  
STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 139

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Chillicothe</u> <u>65920</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hospital</u>			Length of stay in 1b. <u>5 muns</u>		d. STREET ADDRESS (If outside, give location) <u>Municipal Hospital</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Larry</u> Middle <u>Lee</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-20-58</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Chester L. Cooper</u>			13b. MOTHER'S MAIDEN NAME <u>Virginia M. Greenwalt</u>			14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Chester L. Cooper, Meadville, Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abruptio Placenta</u>							INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							7610		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pale Newborn baby never did breathe, heart beat for 30 min</u>							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 WORK <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 _____ and last saw her alive on _____ Death occurred at <u>5:35</u> <u>pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joseph A. Conrad M.D.</u> (Degree or title)				22b. ADDRESS <u>Chillicothe, Mo.</u>			22c. DATE SIGNED <u>May 21-58</u> (Date)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-21-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Meadville</u>		23d. LOCATION (City, town, or county) <u>Meadville, Mo.</u>				
24. FUNERAL DIRECTOR <u>Norman Funerals Home, Chillicothe, Mo.</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>5/21/58</u>		26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>		

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Joseph M. Gibson* .....  
Licensed Embalmer No. *4769* .....  
P. O. Address *Chillicothe* .....

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.