

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033532

STATE FILE NUMBER

FILED OCT 14 1958

Registration District No. 210

Primary Registration District No. 4322

Registrar's No. 58

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Mercer</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Mercer</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Princeton</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Ravanna</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Axtell Hospital</b>		Length of stay in lb <b>4 wks.</b>	d. STREET ADDRESS (If outside, give location) <b>*****</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Cooper</b> Last <b>Cooper</b>			4. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-1880</b>	9. AGE (In years, last birthday) <b>78</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Mercer-County</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Marion Cooper</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Brittain</b>		14. NAME OF HUSBAND OR WIFE <b>Gladys 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>493-42-3106</b>	17. INFORMANT Address <b>Mrs. Gladys Cooper --Ravanna--Mo.</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>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>
DUE TO (b) <b>Meckels Diverticulum and Ruptured</b>					
DUE TO (c) <b>appendix with peritonitis</b>					<b>4 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>5501</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 WORK <input type="checkbox"/> 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>9-10-58</b> to <b>10-7-58</b> and last saw <sup>her</sup> him alive on <b>10-7-58</b> Death occurred at <b>6:15 p.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Byron I. Axtell D.O., 2</b>			22b. ADDRESS <b>Princeton, Mo.</b>		22c. DATE SIGNED <b>10-9-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>10-10-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Half Rock -Cemetery</b>	23d. LOCATION (City, town, or county) <b>Half Rock---Mo.</b>		(State)
24. NAME OF FUNERAL HOME-- <b>RE. Agnew</b>		ADDRESS <b>Princeton --Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-9-58</b>	26. REGISTRAR'S SIGNATURE <b>Paul Math</b>	

(Licensed Embellisher's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *H. E. Agnew* .....

Licensed Embalmer No. *5620* .....

P. O. Address *Princeton, Md*

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.