

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044044

STATE FILE NUMBER

FILED DEC 30 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5867

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</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>Research Hosp.</b>		Length of stay in lb <b>20 yrs</b>	d. STREET ADDRESS <b>2736 Wenzel</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BERNICE</b> Middle Last <b>COOPER</b>			4. DATE OF DEATH Month <b>12</b> Day <b>11</b> Year <b>58</b>		
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>Wh</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-1878</b>	9. AGE (In years (birth day)) <b>80</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Davies County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>No Record</b>		13b. MOTHER'S MAIDEN NAME <b>No Record</b>		14. NAME OF HUSBAND OR WIFE <b>Silas B. Cooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>No</b> <b>xx</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>W.P. Cooper, 4501 Gillham Rd, K.C. Mo</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarct</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Pathological Fract. L. Femur</b> DUE TO (c) <b>due to Multiple Myeloma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 weeks</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>2034</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <b>28 Nov 1958 - 11 Dec 1958</b> and last saw her alive on <b>11 Dec 1958</b> Death occurred at <b>5:30 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Doctor or nurse) <b>F.H. Wakefield M.D.</b>			22b. ADDRESS <b>1102 Grand C. Blvd</b>		22c. DATE SIGNED <b>12-17-58</b>
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE <b>12-13-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Old Town Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pattonsburg Mo.</b>
24. FUNERAL DIRECTOR <b>Wagner Funeral Home, K C Mo</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>12-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Reva Marshall</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

F.H. Wakefield



1:00 to 4:30  
11-2-81

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 *Thomas A. Kahl* .....

Licensed Embalmer No. *5995* .....

P. O. Address *PC, Mo.* .....

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.