

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010813

STATE FILE NUMBER 3137

APR 10 1959 Registration District No. Primary Registration District No. Registrar's No.

S. 300  
- 1-57

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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 causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

|  |                           |   |   |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Adair                                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN Kirksville  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Louis Children's  |                           | Length of stay in 1b<br>5 days  | d. STREET ADDRESS 316 So 6th Street   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br>Dorothy Irene Cooper  |                           |   | 4. DATE OF DEATH Month Day Year<br>Mar. 27, 1959  |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>June 17, 1955   |
| 10a. USUAL OCCUPATION (Give kind of work done during normal working life, even if retired)<br>None   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>None   | 9. AGE (In years last birthday) 3yr<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (City and state or country)<br>Kirksville, Missouri   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   |
| 13a. FATHER'S NAME<br>Donald Eugene Cooper   |                           | 13b. MOTHER'S MAIDEN NAME<br>June Hobbs   | 14. NAME OF HUSBAND OR WIFE<br>None   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No  |                           | 16. SOCIAL SECURITY NO.<br>None   | 17. INFORMANT Address<br>Jane Henrichsen-500 S. Kingshighway                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral anoxia<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) Cardiac arrest during surgery<br>DUE TO (c) Umbilical hernia<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Tracheostomy - 4 days<br>560.2 |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 days<br>4 days<br>life                                      |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>a.m. p.m.  |                           | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                           | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from 3-22-59 to 3-27-59 and last saw her/him alive on 3-27-59<br>Death occurred at 6:22pm on the date stated above; and to the best of my knowledge, from the causes stated.   |                           |   |   |
| 22a. SIGNATURE (Degree or title)<br>Richard Harty M.D.   |                           | 22b. ADDRESS<br>500 S. Kingshighway   | 22c. DATE SIGNED<br>3-27-59   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 23b. DATE<br>3-28-59      | 23c. NAME OF CEMETERY OR CREMATORY<br>Local   | 23d. LOCATION (City, town, or county) (State)<br>Kirksville Mo                                    |
| 24. FUNERAL DIRECTOR<br>Albert H. Hoppe 4700 Washington  |                           | 25. DATE RECD. BY LOCAL REG.<br>MAR 28 '59  | 26. REGISTRAR'S SIGNATURE<br>Loal Smith, M.D.   |

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 *Harvey Kable* .....

Licensed Embalmer No. *4596* .....  
P. O. Address *Florissant, 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.