

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014830

STATE FILE NUMBER

23900

FILED MAY 6 1959

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. 300
1-57
4
29
4
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAINT LOUIS		c. CITY OR TOWN SAINT LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BETHESDA HOSP.		d. STREET ADDRESS (If outside, give location) 4714 MC PHERSON	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES M. COOPER		4. DATE OF DEATH Month Day Year 4-18-59	
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED BARBER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) COLUMBUS, OHIO
13a. FATHER'S NAME WILLIAM COOPER		13b. MOTHER'S MAIDEN NAME LUCY SEABOURNE	14. NAME OF HUSBAND OR WIFE IDA COOPER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 498-26-2172	17. INFORMANT MRS. IDA COOPER, WIFE
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>acute myocardial failure - pul edema</u> <u>massive intestinal hemorrhage</u> DUE TO (b) <u>hemorrhagic gastritis</u> DUE TO (c) <u>hemorrhagic gastritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hours</u>
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.) <u>543x</u>	
20c. TIME OF INJURY Hour Month, Day, Year p.m.		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>4-18-59</u> <u>4-18-59</u>	
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.) <u>4-12-59</u>	
21. I attended the deceased from <u>4-12-59</u> to <u>4-18-59</u> and last saw him alive on <u>4-18-59</u> . Death occurred at <u>Bethesda Hospital 8:25 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>B. L. Bersche</u> (Degree or title) M.D.		22b. ADDRESS <u>5214 Bernard St. St. Louis</u>	
22c. DATE SIGNED <u>4-19-59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>4-21-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Palmer Masonic Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Palmer Mo.</u>
24. FUNERAL DIRECTOR <u>Orman Jenkins</u>		25. DATE RECD. BY LOCAL REG. <u>APR 20 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

(Licensed Embalmer's Statement on Reverse Side)

mrb

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

NO SYMPTOMS WITH DOB TESTING

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 *Murphy L. Sparks*

Licensed Embalmer No. *4236*

P. O. Address *1621 River*

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.