

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020614

STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 226

S. 300
v. 1-57

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

1. PLACE OF DEATH a. COUNTY <i>Cape</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Stoddard</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cape Girardeau</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Puxico</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St Francis Hosp.</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>1030</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Roy</i> Middle <i>-</i> Last <i>Cooper</i>			4. DATE OF DEATH Month <i>June</i> Day <i>19</i> Year <i>1959</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 11 1894</i>	9. AGE (In years last birthday) <i>65</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post master</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Stoddard Co Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13a. FATHER'S NAME <i>Chas. Cooper</i>		13b. MOTHER'S MAIDEN NAME <i>Alta Pearman</i>		14. NAME OF HUSBAND OR WIFE <i>Cora Cooper</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>488-42-1634</i>		17. INFORMANT Address <i>Howard Cooper Kennett Mo</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Right Cerebral Apoplexy;</i> DUE TO (b) <i>Cerebro-vascular Occlusion</i> DUE TO (c) <i>or hemorrhage, P.V. disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 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 <i>334X</i>
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 <i>a.m.</i> Month, Day, Year <i>p.m.</i>					
20d. INJURY OCCURRED WHILE AT <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 <i>June 3rd, 1959</i> to <i>June 19, 1959</i> and last saw him ^{her} alive on <i>June 18, 1959</i> Death occurred at <i>3:30 AM.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>William M. [unclear] MD</i> (Degree or title)			22b. ADDRESS <i>714. [unclear] Mo</i>		22c. DATE SIGNED <i>6-30-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6-21-1959</i>	23c. NAME OF CEMETERY OR GREENHOUSE <i>Puxico</i>		23d. LOCATION (City, town, or county) (State) <i>Puxico Mo</i>	
24. FUNERAL DIRECTOR <i>Gloyd Morgan Puxico Mo</i>		25. DATE RECD. BY LOCAL REG. <i>7-1-1959</i>		26. REGISTRAR'S SIGNATURE <i>Drene Kasten</i>	

1959 JAN 8

VS
AUG 7 1959

JAN 5 1960

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 *Wm H Morgan*

Licensed Embalmer No. *4640*

P. O. Address *Advance 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.