

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039983

FILED VS. NOV. 17, 1959

149

Primary Registration District No. 1002 Registrar's No.

5278

STATE FILE NUMBER

RENDERED

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Length of stay in 1b <u>45 years</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>		Outside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1434 Jefferson</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>M</u> Last <u>COOPER</u>			4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1959</u>			
---	--	--	---	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-4-1897</u>	9. AGE (last birthday) <u>62</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------	-------------------------------	---	-----------------------------------	----------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and state or country) <u>Davenport Iowa</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
--	--	---	---

13a. FATHER'S NAME <u>Perry C. Cooper</u>	13b. MOTHER'S MAIDEN NAME <u>Mary R. Hamilton</u>	14. NAME OF HUSBAND OR WIFE <u>Nellie M. Cooper</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Madellie Cooper - 1434 Jefferson</u>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>acute dilatation of heart.</u>		<u>3 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>myocarditis</u>	<u>2 hours</u>
	DUE TO (c) <u>Cardiac asthma.</u>	<u>3 years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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 _____ a.m. _____ p.m.	Month, Day, Year _____
---	------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>1906</u>	COUNTY _____ STATE _____
---	--	---	--------------------------

21. I attended the deceased from 1906 to 11-2-1959 and last saw him alive on Nov. 2-59.
Death occurred at 11:20 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. James J. Britton M.D.</u>	(Degree or title)	22b. ADDRESS <u>3119 Troost St. KCMo.</u>	22c. DATE SIGNED <u>Nov 3-59</u>
--	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>November 5, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Maunch Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City Missouri</u>
--	--------------------------------------	--	--

24. FUNERAL DIRECTOR <u>Hilko Funeral Home 2345 Linwood</u>	25. DATE RECD. BY LOCAL REG. <u>11-3-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>
--	--	---

DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF JAMES J. BRITTON

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

Chas E. Wilkes

Licensed Embalmer No.

2644

P. O. Address

Kemo

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.