

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 6 3 7

FILED VS JAN - 4 1960

STATE FILE NUMBER

Registration District No. 05 Primary Registration District No. _____ Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>CHARITON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CHARITON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BRUNSWICK, Mo</u>		Length of stay in 1b <u>20 YRS</u>	c. CITY OR TOWN <u>BRUNSWICK</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No. BRUNSWICK</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>No. BRUNSWICK.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>COOPER</u> Last <u>COOPER</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1884</u>	9. AGE (last birthday) <u>75</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>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (City and state or country) <u>CHARITON, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>PLEAS COOPER</u>		13b. MOTHER'S MAIDEN NAME <u>REBECCA</u>		14. NAME OF HUSBAND OR WIFE <u>OMISSIA COOPER</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address _____		

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>Cardiovascular disease</u>		<u>10 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	<u>Arterio Sclerosis</u>	<u>8 yrs</u>
	DUE TO (c)	<u>Cerebral thrombosis</u>	<u>3 yrs</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 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 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 <u>August 06 59 to 30 Dec 59</u> and last saw her/him alive on <u>Dec 30-59</u> Death occurred at <u>5:30 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ernest C. Rose M.D.</u> (Degree or title)		22b. ADDRESS <u>Brunswick, Mo 63103</u>	22c. DATE SIGNED <u>Dec 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-2-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BRUNSWICK Mo.</u>
24. FUNERAL DIRECTOR <u>L. E. McCurry</u>	ADDRESS <u>Brunswick</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 31-1959</u>	26. REGISTRAR'S SIGNATURE <u>Howie Smith</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

GROVER C RICE M.D.

CHAS. O. ...
PT ...

10 ...
18 ...
19 ...

[Handwritten signature]

STATEMENT BY LICENSED EMBALMER

JAN 6 1960

[Handwritten signature]

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 *L. E. McCurry*

Licensed Embalmer No. 4806

P. O. Address *Brunswick*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above conditions 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.