

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**=60-017863**

**FILED VS APR 22 1960**

**317**

Primary Registration District No. **500**

Registrar's No. **1162**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	c. CITY OR TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PENN NURSING HOME</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Unknown</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>COOPER</b> Last <b>COOPER</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 16, 1885</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
10c. CITIZEN OF WHAT COUNTRY		13a. FATHER'S NAME <b>Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
13c. NAME OF HUSBAND OR WIFE <b>Unknown</b>		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. <b>-</b>	
17. INFORMANT <b>Penn Nursing Home</b>		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart disease (Aortic stenosis)</b> DUE TO (b) _____ DUE TO (c) _____ 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) <b>Influenza (1 wk before), left MT Amputee, AS. Dement</b>		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		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		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 <b>Nov 23, 1955</b> to <b>MARCH 8, 1960</b> and last saw him alive on <b>3-1-60</b> Death occurred at <b>12115 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Lewis Lehmann MD</b> (Degree or title)			22b. ADDRESS <b>8231 Clayton Rd (17)</b>		22c. DATE SIGNED <b>3/23/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>4/6/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <b>Rowland-Aker Mortuary Service</b> 4184 Manchester Ave. St. Louis 1		25. DATE RECD. BY LOCAL REG. <b>APR 5 1960</b>		26. REGISTRAR'S SIGNATURE <b>John G. Murphy M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS APR 2 1951

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Anatomical, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Mary Kearney  
Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.