

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042665

FILED VS NOV 22 1960

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 109

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon, Mo.</u>		Length of stay in lb <u>482 days</u>		c. CITY OR TOWN <u>Poplar Bluff,</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>Mo. State Sanatorium</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>201 S. Broadway</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Jefferson</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>14,</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>7-12-79</u>	9. AGE (last birthday) <u>81</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>Iron work foreman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kentucky</u>		11. BIRTHPLACE (City and state or country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William W. M. Cooper</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Ann Weatherford</u>			14. NAME OF HUSBAND OR WIFE <u>unk</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>498-07-2617</u>		17. INFORMANT Address <u>San. records, Mo. State San., Mt. Vernon, Mo.</u>				
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>Pulmonary tuberculosis Far Advanced, Active</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs., approx.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								
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 checked="" 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>7-21-59</u> to <u>11-14-60</u> and last saw <u>him</u> ^{SEX} alive on <u>11-14-60</u> Death occurred at <u>1:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>H. Vernon Lang Cutting M.D.</u>			22b. ADDRESS <u>Mt. Vernon, Mo.</u>			22c. DATE SIGNED <u>11-14-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Nov-14-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Waldenburg Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pinsett County Ark.</u>				
24. FUNERAL DIRECTOR <u>Max L. Fossett</u>			ADDRESS <u>Mt. Vernon Mo</u>	25. DATE RECD. BY LOCAL REG. <u>11-18-60</u>		26. REGISTRAR'S SIGNATURE <u>Max L. Fossett</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max L. Fossell

Licensed Embalmer No. 425
P. O. Address All City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to do so 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.