

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ISSUANCE OF PUBLIC HEALTH AND WELFARE

-61-023754

STATE FILE NUMBER

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 55

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

FILED JUN 16 1961

1. PLACE OF DEATH a. COUNTY <u>Texas</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Texas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Houston, Missouri</u>		c. CITY OR TOWN <u>Summersville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Texas Co. Mem. Hosp.</u>		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>E.</u> Last <u>Cooper</u>			4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1961</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE- <u>W.</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>4/15/86</u>	9. AGE (last birthday) <u>i 75</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Franklin Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>George Shencer</u>			

13b. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>		14. NAME OF HUSBAND OR WIFE			
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>None</u>		17. INFORMANT <u>Henry Cooper</u> Address <u>Smssville, Mo. Rt. 3</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 <u>3 days</u>
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u>	DUE TO (b) <u>Cerebrovascular Accident</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>Cerebral Thrombosis</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	
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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 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
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21. I attended the deceased from May 10, 1961 to May 13, 1961 and last saw her alive on May 13, 1961.
Death occurred at 7:30 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joe G. Wall MD</u>	22b. ADDRESS <u>Houston, Missouri</u>	22c. DATE SIGNED <u>5-22-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/16/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Summersville City Cem.</u>	23d. LOCATION (City, town, or county) <u>Summersville, Missouri</u>
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24. FUNERAL DIRECTOR <u>Quonam Funeral Home Mt. View, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6-13-61</u>	26. REGISTRAR'S SIGNATURE <u>Myrtle Craig m.s.</u>
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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 Charles D. Cantor

Licensed Embalmer No. 5107

P. O. Address Mt. View

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.