

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023839

STATE FILE NUMBER

AMENDED FILED JUL 17 1961 Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 189

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Adair</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirkville, Mo.</u> | | c. CITY OR TOWN <u>Connellsville, Mo.</u> | |
| Length of stay in 1b <u>4 days</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>Laughlin Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>R.T.D.</u> | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Byron Isaac Cooper</u> | | | 4. DATE OF DEATH Month Day Year <u>July 12, 1961</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>11-16-1886</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u> | 9. AGE (last birthday) <u>74</u> |
| 11. BIRTHPLACE (City and state or country) <u>Green City, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>Edward Cooper</u> | | 13b. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Cleo V. 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. | | 17. INFORMANT Address <u>Mrs. Cleo V. Cooper</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>Coronary Thrombosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>one hour</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 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 |
| 21. I attended the deceased from <u>7-9-61</u> to <u>7-12-61</u> and last saw <u>him</u> live on <u>7-12-61</u> Death occurred at <u>12:10 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Richard P. Valuck D.O.</u> | | 22b. ADDRESS <u>Laughlin Hospital</u> | 22c. DATE SIGNED <u>7-13-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7-15-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Green Grove Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Adair Co. Mo.</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Dee Riley Funeral Home, 415 N. Franklin, Kirksville, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>7-14-61</u> | 26. REGISTRAR'S SIGNATURE <u>Doris W. Ratliff</u> |

W.K. Jackson pres (Licensed Embalmer's Statement on Reverse Side)

APR 10 1962

RICHARD P. VALUCK, D.D.

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 Wm K Jackson

Licensed Embalmer No. No = 395

P. O. Address Arkville

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.