

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-006156

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 286

FILED FEB 26 1962

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>DALLAS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		c. CITY OR TOWN <b>Elkland.</b>	
Length of stay in 1b <b>15 days</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DRS' MEMORIAL HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>Route 1</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>B. (Bell)</b> Last <b>Cooper</b>			4. DATE OF DEATH Month <b>February</b> Day <b>17,</b> Year <b>1962</b>		
---	--	--	---	--	--

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-1885</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-------------------------	----------------------------------	---	-------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Ewing, Nebraska</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>Edward Stott</b>	13b. MOTHER'S MAIDEN NAME <b>Melinda Sosbee</b>	14. NAME OF HUSBAND OR WIFE <b>Roy Cooper</b>
---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mrs. Clinton Perry</b>	Address <b>Rt. 1 Elkland, Mo.</b>
---	--	--	--------------------------------------

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) <b>INANITION AND DEBILITATION.</b>		<b>22 DAYS.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>ACUTE LYMPHOID LEUKEMIA</b>	<b>UNKNOWN.</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) <b>NONE</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N. <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 <input type="checkbox"/> a.m. <input type="checkbox"/> 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 <b>Dallas Co. Mo.</b>	COUNTY <b>Dallas Co. Mo.</b>	STATE
--	--	---	---------------------------------	-------

21. I attended the deceased from **2-2-62** to **2-17-62** and last saw her/him alive on **2-17-62**  
Death occurred at **9:00 a** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Harry R. Agnew</i>	(Degree or title) <b>D.O.</b>	22b. ADDRESS <b>700 E. Sunshine Springfield, Mo.</b>	22c. DATE SIGNED <b>2-17-62</b>
---	----------------------------------	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>Feb. 19, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Charity</b>	23d. LOCATION (City, town, or county) (State) <b>Dallas Co. Mo.</b>
--	-----------------------------------	--	--

24. FUNERAL DIRECTOR <b>L. B. Jones</b>	ADDRESS <b>Buffalo, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>2-20-62</b>	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>
--	--------------------------------	--	---

DATE AMENDED  
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

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 R.E. Cheatham

SA-1-S

SA-1-S

SA-1-S

Licensed Embalmer No. 3813

P. O. Address Buffalo, Mo.

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.