

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-021986

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 799

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 16 1982

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Buchanan</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Buchanan</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph, Mo.</u> | | c. CITY OR TOWN <u>St. Joseph</u> | |
| Length of stay in 1b <u>35 yrs.</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>Home</u> | | d. STREET ADDRESS (If outside, give location) <u>210 1/2 Clayton</u> | |
| Inside Limits Yes <input checked="" 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 <u>Lena</u> Middle <u>W.</u> Last <u>Cooper</u> | | | 4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1962</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Negro</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>8/25/89</u> |
| 9. AGE (last birthday) <u>72</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>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>Pine Bluff, Arkansas</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13a. FATHER'S NAME <u>Unknown</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 14. NAME OF HUSBAND OR WIFE <u>Ben 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. <u>Unknown</u> | 17. INFORMANT Address <u>Mrs. Aretta Thomas - 1708 Bishop St. - Little Rock, Arkansas</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>Generalized Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> | | | <u>Unknown</u> |
| 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 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 <u>St. Joseph, Mo.</u> | COUNTY _____ STATE _____ |
| 21. I attended the deceased from <u>4/19/62</u> to <u>7/3/62</u> and last saw her <u>per</u> alive on <u>6/19/62</u> | | Death occurred at <u>7:30 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) <u>D.E. Sklenar MD</u> | | 22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u> | 22c. DATE SIGNED <u>7/5/62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>July 7, 1962</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sun Bridge Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>St. Joseph Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Beatrice Gray</u> | ADDRESS <u>812 Pacific St</u> | 25. DATE RECD. BY LOCAL REG. <u>July 11, 1962</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u> |

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

DESKLNER MD CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59

15117

25117

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1290-0

131-0

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 John T. Miles

Licensed Embalmer No. 3446

P. O. Address Atchison, KS

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.