

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-049270

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

PK

AMENDED

Registration District No. 252 Primary Registration District No. \_\_\_\_\_ Registrar's No. 126

FILED JAN 14 1963	
1. PLACE OF DEATH a. COUNTY <b>Taney</b>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Taney</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Forsyth</b> Length of stay in 1b _____	
c. CITY OR TOWN <b>Branson</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> # _____	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lakeview Rest Home</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> # _____	
d. STREET ADDRESS <b>Long Beach Road</b> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SILAS W. COOPER</b>	
4. DATE OF DEATH Month Day Year <b>Dec. 22, 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/1883</b>
9. AGE (last birthday) <b>79</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>farmer</b>	
11. BIRTHPLACE (City and state or country) <b>Quincy Ill</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Lewis Cooper</b>	
13b. MOTHER'S MAIDEN NAME <b>Jane Dix</b>	
14. NAME OF HUSBAND OR WIFE <b>none</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes WWI</b>	
16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT Address <b>Mrs Beatrice Bynum Branson, Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <b>Hydrostatic Pneumonia</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Ayapoplexy</b>	
DUE TO (c) <b>Arterial Hypertension</b>	
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 <b>11-24-62</b> to <b>12-22-62</b> and last saw her him alive on <b>12-22-62</b> Death occurred at <b>7:40 A.m</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Mary King, D.O.</b>	
22b. ADDRESS <b>Forsyth, Mo.</b>	
22c. DATE SIGNED <b>12-29-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE <b>12/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ozark Mem.</b>	
23d. LOCATION (City, town, or county) (State) <b>Branson, Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Walter Cobb Branson, Mo</b>	
25. DATE RECD. BY LOCAL REG. <b>1-7-63</b>	
26. REGISTRAR'S SIGNATURE <b>Seleu Campbell</b>	

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

VS 300 Rev. 4/59

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JAN 18 1963

FEB 19 1963

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed (T) by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Walter Cobb

Licensed Embalmer No. 4731

P. O. Address Blauvelt, N.Y.

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.