

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-023478

STATE FILE NUMBER

Registration District No. 47 Primary Registration District No. 5164 Registrar's No. 193

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 2 1963

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton Twp</u>		Length of stay in 1b <u>1Y 8M 9D</u>	c. CITY OR TOWN <u>Jefferson Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Modern Acres Nursing Hse</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <u>South of Belle Mo.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA VIOLA COOPER</u>			4. DATE OF DEATH Month Day Year <u>June 24, 1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>7/10/82</u>	9. AGE (last birthday) <u>80</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>Housewife</u>	11. BIRTHPLACE (City and state or country) <u>Maries County Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>H. L. THOMPSON</u>		13b. MOTHER'S MAIDEN NAME <u>ELLA YATES</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES COOPER (DEC)</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>Mr. Roy C. Smith, La Monte Mo</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</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>1959</u> to <u>present</u> and last saw her alive on <u>4-29-1963</u> Death occurred at <u>6:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED (State) <u>10-27-63</u>	
22a. SIGNATURE (Degree or title) <u>James E. Hice MD</u>		22b. ADDRESS <u>Fulton Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>6/26/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cem.</u>	23d. LOCATION (City, town, or county) <u>Belle Mo</u>
24. FUNERAL DIRECTOR <u>Howard Jones Belle Mo</u>		25. DATE RECD. BY LOCAL REG. <u>June 27 - 1963</u>	
		26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

JUL 3 1968

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STATEMENT BY LICENSED EMBALMER

0-22

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 Orin Howard Jones

Licensed Embalmer No. 4411

P. O. Address Belle Me.

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.