

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-032854**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 204

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

**FILED SEP 11 1963**

VS 300  
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>LIVINGSTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>LIVINGSTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CHILLICOTHE</b>		Length of stay in 1b <b>20 YEARS</b>	c. CITY OR TOWN <b>CHILLICOTHE</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CITY HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>418 ELM ST.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ARCHIE FRANKLIN COOPER</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>4</b> Year <b>1963</b>
5. SEX <b>MALE</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>8/6/1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	9. AGE (last birthday) <b>58</b> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Hours Min.
11. BIRTHPLACE (City and state or country) <b>LIVINGSTON CO. MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>LEE ROY COOPER</b>		13b. MOTHER'S MAIDEN NAME <b>LILLIE BELLE CLOWDIS</b>	
14. NAME OF HUSBAND OR WIFE <b>FERN SCRUBY</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>9</b>		17. INFORMANT <b>MRS. FERN COOPER</b> <b>418 Elm St. Chillicothe, Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>
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 <b>Sept 4 1963</b> and last saw <sup>her</sup> him alive on <b>Sept 4-1963</b> Death occurred at <b>8:45</b> A.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>D.O.</b>		22b. ADDRESS <b>Chillicothe Mo.</b>	22c. DATE SIGNED <b>9-4-63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6 Sept 63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESTHAVEN CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CHILLICOTHE, MISSOURI</b>
24. FUNERAL DIRECTOR <b>NORMAN FUNERAL HOME: CHILLICOTHE, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>6 Sept 63</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>

USE BLACK INK OR TYPEWRITER RIBBON

Date Taken to Dr. Elliott 9/4/63  
Date Received from Dr. Elliott  
P. N. 0 - 0 4  
P. N. 4

SEP 12 1963

SEP 27 1963

**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 P. Rodgers

Licensed Embalmer No. 4963

P. O. Address CHILLICOTHE, MISSOURI

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.