S. No. 300
v. 10-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED DEC 2 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37001

BIRTH NO. _____ REG. DIST. NO. 131 PRIMARY REG. DIST. NO. 4202 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY: GRUNDY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SPICKARD
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY: GRUNDY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SPICKARD
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) SOLOMON b. (Middle) c. (Last) COOPER

4. DATE OF DEATH: (Month) NOV (Day) 23 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: MAY 3 1878

9. AGE (In years last birthday): 71 IF UNDER 1 YEAR Months 6 Days 20 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): KANSAS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: THOMAS COOPER

13b. MOTHER'S MAIDEN NAME: AMANDA BURRIS

14. NAME OF HUSBAND OR WIFE: SARAH COOPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: SARAH COOPER SPICKARD MO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia; etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Organic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?:

22. *I hereby certify that I attended the deceased from* Did not treat Patient ~~found dead when arrived~~ 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. W. Ewing MD

23b. ADDRESS: Spickard Mo

23c. DATE SIGNED: 11-25-49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: NOV-25-1949

24c. NAME OF CEMETERY OR CREMATORY: HALF ROCK CEM.

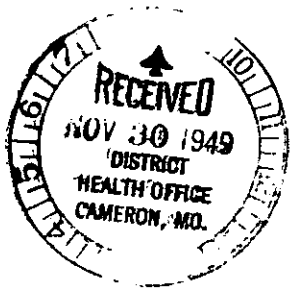
24d. LOCATION (City, town, or county) (State): HALF ROCK MO

DATE REC'D BY LOCAL REG.: 11/26/49

REGISTRAR'S SIGNATURE: Mrs Nathan Cooper

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Schooler Funeral Home Spickard Mo

(Licensed Embalmer's Statement on Reverse Side)



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 .....
Student Embalmer

Signed Rose Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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 this body is not embalmed, fact should be so stated above.