N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D JUL 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

20600

Do not use this space.

1 791

1. PLACE OF DEATH
   (a) County ..... 2 Registration District No. 1008
   (b) Township ..... Primary Registration District No. ..... Registered No. 5739
   (c) City St. Louis (d) Street No. Missouri Baptist Hospital St.
   (If death occurred in Hospital or Institution, write its name instead of street and number)
   (e) Length of residence in city or town where death occurred yrs. mos. 16 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Thomas Cooper 160
   (a) Residence, No. ..... St. NR Viola, Ark.
   (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Olive Cooper

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 3, 1874

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
64	2	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) May 1938
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Melbourne Ark.

FATHER
13. NAME John R. Cooper
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER
15. MAIDEN NAME Nancy Elizabeth Haley
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

17. INFORMANT (ADDRESS) Olive Cooper Viola, Ark.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Viola Ark. DATE 6-26, 1938

19. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc. (ADDRESS) 429 North Euclid Ave.

20. FILED JUN 25 1938 J. D. Bredick Local Registrar.

MEDICAL CERTIFICATE OF DEATH 23

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June ~~23~~, 1938

22. I HEREBY CERTIFY, That I attended deceased from June 7, 1938, to June 23, 1938
I last saw him alive on June 23, 1938. Death is said to have occurred on the date stated above, at 10:50 p.m.
The principal cause of death and related causes of importance were as follows:

① Uremia, caused by Peritonitis same caused by gall bladder condition

Date of onset ① 6/16/38 ② Indefinite

Other contributory causes of importance:
② Cholelithiasis

126

Name of operation Cholecystectomy Date of 6/18/38
What test confirmed diagnosis? Operation Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify ..... (KIEFFER)
(Signed) Roland Stieffer, M. D.
(Address) 4500 Olive

(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 .....

Registered Apprentice No....., working under my personal supervision.

Signed Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.