REC'D JUN 20 1939

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

19440
Do not use this space.

1. PLACE OF DEATH
(a) County Pettis
(b) Township
(c) City Sedalia
Registration District No. 668
Primary Registration District No. ~~146~~ 3032
Registered No. ~~668~~ 146
(d) Street No. Bothwell 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 160 Charles M. Cooper
(a) Residence, No. 510 East 13th. St.
(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: Blanche Cooper
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Jan. 20, 1870
7. AGE: YEARS 69 MONTHS 3 DAYS 9 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Unemployed
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)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Spring Fork Mo.

FATHER
13. NAME: Jonas F. Cooper
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Va.

MOTHER
15. MAIDEN NAME: Margaret Ann Perry
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): W. Va.

17. INFORMANT (ADDRESS): Mrs. C. M. Cooper Sedalia, Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Crown Hill DATE May 1, 1939, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Gillespie Funeral Home Sedalia, Mo. 906
20. FILED May 1, 1939 Mrs Harry Sneed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 29/39, 19

22. I HEREBY CERTIFY, That I attended deceased from April 1, 1939, to April 29, 1939
I last saw him alive on April 29th, 1939. Death is said to have occurred on the date stated above, at 12.50 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemorrhage and Acute Suppression of Urine following Prostatectomy 4-28-39	28 hours

Other contributory causes of importance:

Arteriosclerosis	?

Name of operation Prostatectomy Date of 4-28-39
What test confirmed diagnosis? Findings Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury ....., 19....
Where did injury occur? No
(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
(Signed) Jno B. Carlisle M.D., M. D.
5-1-39 (Address) Sedalia Mo

Licensed Embalmer's Statement on Reverse Side)

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

...THIS IS A PERMANENT RECORD

RECEIVED
District Health Officer No. 8,
District File Number 6/8/39
Date Filed

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, ...

Geo. Dillard, or by .....

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

Signed Geo. Dillard

Licensed Embalmer No. 3868

P. O. Address Sedalia, 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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

19440
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1. PLACE OF DEATH
(a) County Pettis — Registration District No. 668
(b) Township — Primary Registration District No. 3032 — Registered No.
(c) City Sedalia — (d) Street No. ..... 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. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Charles M. Cooper
(a) Residence, No. ..... St. ☐ .....
(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: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): M

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

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

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
69	3	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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)
11. Total time (years) spent in this occupation

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

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr 29, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19....
I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Hemorrhage & acute suppression of urine following Prostatectomy	
Other contributory causes of importance: arteriosclerosis	
Hypertrophy of Prostate	1936

Name of operation Prostatectomy Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....
If so, specify .....
(Signed) John B. Carlisle, M. D.
(Address) Sedalia Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.