

NOV 13 1939

791

1008

Registration District No. _____

Primary Registration District No. _____

Registrar's No. 8456

1. PLACE OF DEATH:

(a) County 1
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Homer Phillips
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Since 8/30/39
 (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Tom Cooper /60
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Ida Cooper 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Jan. 1, 1881
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 8 3 hr. min.

9. Birthplace Mississippi
 (City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name George Cooper

13. Birthplace Mississippi
 (City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Evelyn Stillard

(b) Address 2601 N Whittier

17. (a) _____ (b) Date thereof 9-11-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director W. R. Raftery

(b) Address 3590 Rector

19. (a) OCT 3 1939 (b) _____
 (Date of local burial) (City or county)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis 26
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1524 N 9th
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
 year 1939 hour 1 minute 15 a. M.

21. I hereby certify that I attended the deceased from 8/30/39
 _____, 19____ to 9/4/39, 19____;
 that I last saw h. im. alive on 9/4/39, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Gastric malignancy sbt. 18
 MO.

Due to --

Due to --

Other conditions --
 (Include pregnancy within 3 months of death)

Major findings: Of operations --

Of autopsy --

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. J. Lyman (M. D. or other)

Address 2601 N Whittier Date signed 9/11/39

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.....

Licensed Embalmer No.....

P. O. Address.....

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.