

Registration District No. 2183

Primary Registration District No. 5402

1. PLACE OF DEATH:
(a) County Dunklin Mo.
(b) City or town Cardwell Rural
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days all their lives

3. (a) PRINT FULL NAME IVAN WAYE COOPER 160
8. (b) If veteran, name war _____ 8. (c) Social Security No. _____
4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Infant
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11-26-39
(Month) (Day) (Year)

8. AGE: Years _____ Months 0 Days 4 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

FATHER { 12. Name James Edward Cooper
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
MOTHER { 14. Maiden name Flora Mae Mann
15. Birthplace Rector Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. Maudie Morgan
(b) Address Cardwell, Mo.

17. (a) Burial (b) Date thereof 12-1-39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cardwell Cemetery

18. (a) Signature of funeral director Home made
(b) Address _____

19. (a) 11-30-39 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dunklin
(c) City or town Cardwell Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 30
year 39 hour 7:30 minute A. M.
21. I hereby certify that I attended the deceased from 11-26, 1939, to 11-30, 1939, that I last saw him alive on 11-26, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death Bell Pains
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 7 1/2

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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 Mary E. Hill (M. D. or other) NEARBY
Address Cardwell, Mo. R 1 Date signed 11-30-39

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

Rev. 5-17-39

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.

RECEIVED

District Health Officer No. _____

District File Number 1239-7

Date Filed 12/15/39

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

39506

Do not use this space.

1. PLACE OF DEATH

(a) County Dunklin Registration District No. 283
 (b) Township Buffalo Primary Registration District No. 3402 Registered No.
 (c) City (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (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 Walter Wayne 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 mf
(write the word)

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.
4

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 1-10 40 Newsom
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-30-1937

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him 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:

Ball Throat Date of onset

Other contributory causes of importance:

Name of operation 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) Newsom, Local Registrar

(Address) Cardwell, Mo.

SUPPLEMENTAL

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.

