

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 5378

1. PLACE OF DEATH:

(a) County Isolation Hospital
(b) City or town St. Louis, Mo.
(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 4/5/40 6/20/40
(Specify whether
in this community
years, months or days)

3. (a) PRINT FULL NAME Sarah Cooper 160

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race Colored 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 17th, 1908
(Month) (Day) (Year)

8. AGE: Years 32 Months 11 Days 3 If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Mo. (City, town, or county) Missing (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name Edward Cooper
13. Birthplace Goodwin, Miss. (City, town, or county) (State or foreign country)
14. Maiden name Frances Robertson
15. Birthplace Goodwin, Miss. (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address 5600 Arsenal St.

17. (a) BURIAL (b) Date thereof 6/24/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis, Ill.

18. (a) Signature of funeral director [Signature]

(b) Address 5517 Soledad Ave

19. (a) JUN 22 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State St. Louis, Mo (b) County _____
(c) City or town 25
(If outside city or town limits write "RURAL")
(d) Street No. 1439 a N. 10th
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20th 1940
year _____ hour 10:30 AM/minute _____ M.

21. I hereby certify that I attended the deceased from 4/5/40
_____ 19____, to 6/20/40 _____ 19____;
that I last saw her alive on 6/20/40 10:30 AM _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
Syphilitic
Due to Syphilitic aortitis

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy none

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 [Signature] (M. D. or other) _____
Address Isolation Hosp, St. Louis Date signed 6/21/40

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

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.....
.....
working under my personal supervision.

Signed

P. H. Green

Registered Apprentice No.

Licensed Embalmer No. 1123

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.