

No. 2
11-10-39
FILED

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30876**
Registrar's No. **3439**

OCT 11 1940

399

1002

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Polyclinic Hospital, 2426 Indep. Ave.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Weeks
(Specify whether
In this community 50 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 1527 White Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? -- years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September Day 1
year 1940 hour 6 minute 40 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on Aug. 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Arterio Sclerosis

Due to Chronic myocarditis

Other conditions (Include pregnancy within 3 months of death) 93c

Major findings: Of operations _____

Of autopsy _____

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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury 2

23. Signature M. M. Cronel (Mr. Dr. or other)
Address 303 Alhambra Bldg Date signed 9/1/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME Mr. Wilson Edward Cooper

8. (b) If veteran, name war Not a veteran No. None 3. (c) Social Security _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Emma Lena Cooper 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased November 25 1864
(Month) (Day) (Year)

8. AGE: Years 75 Months 9 Days 6 If less than one day _____ hr. _____ min.

9. Birthplace Aberdeen County Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Retired

12. Name Unknown

13. Birthplace Unknown Unknown
(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 Missie Rogers

(b) Address St. Louis 9th

17. (a) Burial (b) Date thereof Sept. 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Moriah Cemetery

18. (a) Signature of funeral director D. H. Newcomer

(b) Address 1401 Brush Creek Blvd.

19. (a) Sept. 3, 1940 (b) M. M. Cronel
(Date received local registrar) (Registrar's signature)

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

MOTHER, FATHER

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address K.C., 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.