

No. 2
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7-39
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RECEIVED JAN 23 1941
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

44070

State File No. _____

Registration District No. 838

Primary Registration District No. 4509

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter - Mo.
(If outside city or town limits, write "RURAL" and name of township)

(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 2

3. (a) PRINT FULL NAME Georgia Sue Cooper

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced ✓

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased Dec 25 1940
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>1</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Eldon Cooper

{ 13. Birthplace Bloomfield - Mo R. 1
(City, town, or county) (State or foreign country)

{ 14. Maiden name Georgia Bailey

{ 15. Birthplace New Mexico
(City, town, or county) (State or foreign country)

16. (a) Informant Eldon Cooper

(b) Address Bloomfield - Mo R. 1

17. (a) Burial (b) Date thereof 12-25-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ogden Ridge

18. (a) Signature of funeral director Dallas Funeral Service
(b) Address Dexter - Mo

19. (a) 1/8/1941 (b) Jennie Weston
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard

(c) City or town Dexter Mo
(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 Dec. day 25
year 1940 hour 12:30 minute AM

21. I hereby certify that I attended the deceased from Dec. 25 1940, to Dec. 25 1940, that I last saw her alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Difficult labor

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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? _____

23. Signature D. J. Cannon (M. D. or other) DO
Address Dexter Date signed 1/7/41

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

RECEIVED
District Health Officer
District File Number 141
Date Filed 1/9/4

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.