

Registration District No. 44-168

Primary Registration District No. 55875611

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Leeton RFD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: First Oak Surg
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 63 yrs. years, months or days

3. (a) PRINT FULL NAME Robert Collins Cooper

3. (b) If veteran, name war NO - 3. (c) Social Security No. NO -

4. Sex Male 5. Color or race O 6. (a) Single, widowed, married, divorced 1
6. (b) Name of husband or wife Francis Cooper 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Oct. 20, 1867
(Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 30 If less than one day : _____ hr. _____ min.

9. Birthplace Johnson Co. Mo. (1)
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

MOTHER FATHER { 11. Industry or business _____

12. Name Thomas Jefferson Cooper
13. Birthplace Johnson Co. Mo. (1)
(City, town, or county) (State or foreign country)
14. Maiden name Nancy Davis
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. R. Leo Cooper
(b) Address Waverly, Mo.
17. (a) Removal (b) Date thereof 8-21-42
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Waverly, Mo.

18. (a) Signature of funeral director RA Branning
(b) Address Leeton, Mo.

19. (a) 8-20-42 (b) RA Branning
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson
(c) City or town Leeton
(If outside city or town limits, write "RURAL")
(d) Street No. RFD No 71
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 19th year 1942 hour 6:00 minute PM M.

21. I hereby certify that I attended the deceased from Dec. _____, 1942 to Aug 19, 1942 that I last saw him alive on Aug 14, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration _____
Chronic Interstitial Nephritis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 1218

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 RA Branning (M. D. or other) _____
*Address Waverly, Mo. Date signed 8-20-42

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

51
00

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 me

....., Registered Apprentice No.....
working under my personal supervision.

Signed J. M. Bruminger

Licensed Embalmer No. 3377

P. O. Address Leeton, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27503

Registration District No. 168

Primary Registration District No. 5611

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town _____
(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 6.3 yrs. years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Robert Calvin Cooper

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

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

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

7. Birth date of deceased Oct 20 1867 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 3 (If less than one day) _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-20-42 (b) J.P. Branning (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

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

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

