

FILED MAY 29 1943

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 18942

Registration District No. 577

Primary Registration District No. 6076

Registrar's No. 1220

1. PLACE OF DEATH:

(a) County **St. Louis County**  
(b) City or town **Jefferson Barracks**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Veterans Administration Facility**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **Adm. May 20, 1943**  
(Specify whether since **5/20/43**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Dent**  
(c) City or town **Salem**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Route #2**  
(If rural, give location)  
(e) Citizen of foreign country? **-** (Yes or No)  
If yes, name country **-**

3. (a) PRINT FULL NAME **OTTO E. COOLEY**

3. (b) If veteran, name war **World War #1** 3. (c) Social Security No. **Yes - not remembered**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Dora** 6. (c) Age of husband or wife if alive **38** years

7. Birth date of deceased **July 15, 1895**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**47 10 6** hr. min.

9. Birthplace **Salem Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Dairy Farmer**

11. Industry or business **-**  
12. Name **Edward Cooley**

13. Birthplace **Salem Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Ruth Chestnut**

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

16. (a) Informant **M. Schullig**

(b) Address **Clinical Clerk, VAF, Jeff Bks., Mo.**

17. (a) **Burial** (b) Date thereof **5/22/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Salem, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**  
(b) Address **4700 Washington Blvd.**

19. (a) **MAY 25 1943** (b) **C. H. McFarland, M.D.**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **21st.**  
year **1943** hour **3:20** minute **P.** M.

21. I hereby certify that I attended the deceased from **May 20, 1943** to **May 21, 1943**  
that I last saw him alive on **May 21, 1943**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of pylorus and duodenum with intra-abdominal metastases, extensive.**  
Due to **-** **Abt. 15 Mo.**

Other conditions **None**  
(Include pregnancy within 3 months of death)

Major findings: Of operations **-**  
Of autopsy **No autopsy.**

Duration

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) **no**  
(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) Means of injury

23. Signature **L. M. COCHRAN, M.D.** (M. D. or other)  
Address **Chief Medical Officer, VAF, Adm. Fac., Jeff. Bks., Mo.** Date signed **5/21/43**

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

76  
50

NO. 2 NBS

DATE  
TIME

DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

DATE

TIME

DEPARTMENT OF HEALTH

STATE OF NEW YORK

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

**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.....

Licensee No. 4200

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, fact should be so stated above.**