

No. 2
-5-42
-17-39
X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25075
Registrar's No. 40

Registration District No. 740

Primary Registration District No. 3024

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

1. PLACE OF DEATH: Howard,
(a) County Howard,
(b) City or town Fayette, 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 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 45
Missouri
(a) State Missouri (b) County Howard,
(c) City or town Fayette, Mo.
(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 John Cooper,
FULL NAME
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Black
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 Unknown,
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
63 hr. min.

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

10. Usual occupation Laborer,

11. Industry or business _____

MOTHER FATHER

12. Name Unknown
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Unknown,
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Molly Walker,
(b) Address Fayette, Mo.
17. (a) Burial, (b) Date thereof 6-16-1943
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery,

18. (a) Signature of funeral director Guy T. Halley,
(b) Address Fayette, Mo.
19. (a) 6-16-1943 (b) Ernest W. Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 12
year 1943 hour 5:30 minute 0 M.
21. I hereby certify that I attended the deceased from only 5 days
before death, 1943 to 6-12- 1943
that I last saw him alive on _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilation of heart
Due to Ch. Myocarditis
Duration 1 day

Other conditions _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations _____
Of autopsy _____

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 Ernest W. Williams (M. D. or other) M.D.
Address Fayette Mo Date signed 6-16-43

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 7-13-43

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 _____

Guy T. Kneen

Licensed Embalmer No. 2966

P.O. Address Jayville, 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, fact should be so stated above.

EX-108 P.M.

Registration District No. 140

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Wright
(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)

3. (a) PRINT FULL NAME John Cooper

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ min

9. Birthplace Howard County, Missouri (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 _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Ernest W. Miller
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day _____
year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____;
that I last saw him _____ at _____ 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)
(c) Means of injury _____

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

Address _____ Date signed _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY - USE FADING BLACK INK - MAKE A PERMANENT RECORD

SUPPLEMENTARY

5-25078