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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

42030

State File No.

FILED JAN 10 1944
Registration District No. 2944

Primary Registration District No. 5299

Registrar's No. 74

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

1. PLACE OF DEATH: *Clinton*

(a) County *Clinton*

(b) City or town *Rural Lathrop*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *1*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *90 yrs.* (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Clinton*

(c) City or town *RURAL*
(If outside city or town limits, write "RURAL")

(d) Street No. *LATHROP TOWNSHIP*
(If rural, give location)

(e) Citizen of foreign country? *NO* (Yes or No)

If yes, name country *0*

3. (a) PRINT FULL NAME *JAMES SAMUEL COOPER*

3. (b) If veteran, name war: *0*

3. (c) Social Security No. *0*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *4* year *1943* hour *8* minute *30 p* M.

4. Sex *Male* 5. Color or race *White*

6. (a) Single, widowed, married, divorced *2*

6. (b) Name of husband or wife *0*

6. (c) Age of husband or wife if alive *17* years

7. Birth date of deceased *Nov 5 1853*
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from *11-15-43* 19 *11-29-43-12-4-43* that I last saw him alive on *11-29-43* and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<i>90</i>	<i>0</i>	<i>29</i>	hr. min.

Immediate cause of death *Fracture of hip 11-15-43 to 12-4-*

Due to *Fall*

9. Birthplace *Ray County Mo. 0*
(City, town, or county) (State or foreign country)

10. Usual occupation *FARMER*

Due to *Infirmities of old age*

Other conditions *0*
(Include pregnancy within 3 months of death)

11. Industry or business *FARMING Retired*

12. Name *John G. Cooper M.C. 1*

13. Birthplace *0*
(City, town, or county) (State or foreign country)

14. Maiden name *Sarah E. Law*

15. Birthplace *TENN. 1*
(City, town, or county) (State or foreign country)

Major findings: *1866*
Of operations *11*

Of autopsy *11*

16. (a) Informant *M. J. Cooper*

(b) Address *Lathrop Mo*

17. (a) *Burial* (b) Date thereof *12-6-1943*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Lathrop Mo*

18. (a) Signature of funeral director *W. Moss Grunk*

(b) Address *Lathrop Mo*

19. (a) *12-6-1943* (b) *Mrs. Kathleen Harris*
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *accident 19.5*

(b) Date of occurrence *Nov-15-43*

(c) Where did injury occur? *His home - Clinton Mo.*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home Near Lathrop
(Specify type of place)

While at work? *0* (e) Means of injury *Fall*

23. Signature *E. B. Dinkler* (M. D. or other)

Address *Lathrop Mo* Date signed *12-6-43*

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1086

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, ^{NOT} ~~or by~~

.....
working under my personal supervision.

Signed.....

Registered Apprentice No.

Licensed Embalmer No. *2533*

P. O. Address. *Lathrop, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH

(a) County Clinton
 (b) City or town Rural
(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 90 yr. years, months or days) (Specify whether

3. (a) PRINT FULL NAME James S. Cooper

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced widow

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

7. Birth date of deceased Nov. 5
(Month) (Day) (Year)

8. AGE: Years 90 Months 0 Days 0 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 1-17-44 (b) Mrs. Kathleen Hayes
(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 Dec day 1 year 1943 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 _____

Duration

Due to _____

Due to _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

S-42030