

No. 2
8-43
17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18950

State File No.

FILED JUN 12 1944
Registration District No. 12944

Primary Registration District No. 3056

Registrar's No. 117

1. PLACE OF DEATH:

(a) County Randolph

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

(c) Name of hospital or institution:
508 Patton St
(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. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Randolph

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

(d) Street No. 508 Patton
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Ida Cooper

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

4. Sex Female Color or race col

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

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

7. Birth date of deceased Aug 27-1888
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May, day 10, year 1944, hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from 5-7-44 to May 7 1944, to 5-10 1944, that I last saw her alive on 5-9-1944 and that death occurred on the date and hour stated above.

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

56 8 11 hr. min.

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

10. Usual occupation Wf

11. Industry or business.....

12. Name Dud Wilson

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

14. Maiden name Mattie Wilson

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

16. (a) Informant Mrs Herbert Bailey

(b) Address 508 Patton

17. (a) Burial (b) Date thereof 5-12-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director Robert M. Carr

(b) Address Mobile Mo

19. (a) 5-10-44 (b) Ida Cooper
(Date received local registrar) (Registrar's signature)

Immediate cause of death Apoplexy

Due to.....

Due to.....

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

Major findings: Of operations.....

Of 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).....

(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?.....

(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature R. H. Williams (M. D. or other).....

Address 401 1/2 W. Reed Mobile Mo Date signed 5-10-44

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

MOTHER FATHER

1036

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 6-44-1070

Date Filed JUN 9 1944

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 Robert L. Carr

Licensed Embalmer No. 3190

P. O. Address Moberly 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.

Registration District No. 244 Primary Registration District No. 3056

1. PLACE OF DEATH:

(a) County Randolph
(b) City or town Moberly
(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 Ida Cooper
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race B 6. (a) Single, widowed, married, divorced wid.
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 27 1881
(Month) (Day) (Year)
8. AGE: Years 56 Months _____ Days _____ (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) (Burial, cremation, or removal) _____ (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Emma Nave
(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 May 1944 year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death apoplexy

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

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

SUPPLEMENTARY

MOTHER FATHER

18950