S. No. 2
M—5-43
v. 5-17-39
o I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED MAR 23 1945

State File No. 7589

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2266

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
Bethesda Hospital 0
(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: 000

(a) State Mo. (b) County 17.6

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3419 Arlington Ave.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME GarryM. Cooper

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. (Month) 16 (Day) 1930 (Year)

8. AGE: Years 14 Months 4 Days 23 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Vernon Cooper
13. Birthplace Charleston (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Flejane Prosser
15. Birthplace (City, town, or county) Ind. 1 (State or foreign country)

16. (a) Informant Vernon Cooper
(b) Address 3419 Arlington Ave

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-10-45 (Month) (Day) (Year)
(c) Place: burial or cremation Charleston Mo.

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.

19. (a) MAR 10 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 9
year 1945 hour 9 minute 35 P.M.

21. I hereby certify that I attended the deceased from 3/5, 1945, to 3/9, 1945
that I last saw him alive on 3/9/45, 19
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death cardiac failure due to rheumatic heart disease	
Due to rheumatic fever	Jan 1945
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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Thomas C Bredeck (M. D. or other) M.D.
Address 4660 Maryland Date signed 3/10/45

(Licensed Embalmer's Statement on Reverse Side)

4660 Maryland Ave.

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 Warren A. Carver

Licensed Embalmer No. 3534

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.