

FILED FEB 28 1948

383

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____

Primary Registration District No. 5655

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Mt. Vernon
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1541 days
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME Homer C. Cooper

3. (b) If veteran, name was No
 3. (c) Social Security No. None

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

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

7. Birth date of deceased Oct. 20 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>2</u>	<u>25</u>	_____ hr. _____ min.

9. Birthplace Howard County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Joseph Cooper

13. Birthplace Howard County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Maryanne Smith

15. Birthplace Howard County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San, Mt. Vernon, Mo.

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

(c) Place: burial or cremation Fayette, Mo.

18. (a) Signature of funeral director Notary

(b) Address Mt. Vernon, Mo.

19. (a) 1-15-46 (b) DR Phillips
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howard
 (c) City or town Fayette
(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 January day 14th
 year 1946 hour 8:50 minute _____ P. M.

21. I hereby certify that I attended the deceased from October 26th to Jan. 14, 1946
 that I last saw him alive on Jan 14th, 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Over 5 yrs.
 Duration

Due to _____

Due to _____

Other conditions The Nephritis and Cystitis
(include pregnancy within a month of death) Uremia Duration unknown

Major findings: Of operations _____

Of autopsy 12/11

Underline the cause to which death should be charged statistically.
 PHYSICIAN

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 Y. F. ... (M. D. or other) MO.
 Address Mt. Vernon, Mo. Date signed 1-14-46

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

RECEIVED

District Health Officer No. 6,

District File Number 146-154

Date Filed FEB 26 1946

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 H. D. Fossett

Licensed Embalmer No. 2201

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.