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

FILED MAR 28 1946

Registration District No. 338

Primary Registration District No. 4501

State File No. 8228

Registrar's No.

1. PLACE OF DEATH:

(a) County Stoddard

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

(c) Name of hospital or institution:
R. S. Davis Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Days
(Specify whether)

In this community 1 year
years, months or days

3. (a) PRINT FULL NAME Carson Vern Cooper

3. (b) If veteran, name war ---

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife ---

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

7. Birth date of deceased: Jan. 24, 1945
(Month) (Day) (Year)

8. AGE: Years 1 Months -- Days 8
If less than one day --- hr. --- min.

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

10. Usual occupation ---

11. Industry or business ---

MOTHER FATHER {

12. Name Raymond Cooper

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

14. Maiden name Blanch Mason

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

16. (a) Informant Raymond Cooper (Father)

(b) Address Bloomfield, Mo.

17. (a) Burial (b) Date thereof Feb. 4-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Ridge Cem.

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) Feb. 12, 1946 (b) Earl Chiles
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard/03

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country ---

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 3rd
year 1946 hour 6:05 minute A. M.

21. I hereby certify that I attended the deceased from 2-1-46 19. to 2-3-46 19. ;
that I last saw him alive on 2-3-46 19. ;
and that death occurred on the date and hour stated above.

Immediate cause of death PNEUMOCOCCIC MENINGITIS Duration 20 HRS

Due to BRONCHIAL PNEUMONIA 48 HRS

Due to ACUTE DORYZA

Other conditions (Include pregnancy within 3 months of death) ---

Major findings:
Of operations ---

Of autopsy 107

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? ---

23. Signature [Signature] (Specify type of place) (City or town) (County) (State) ---
While at work? (e) Means of injury ---

23. Signature [Signature] (a) or (b) or (c) or (d) or (e) ---
Address BLOOMFIELD Date signed 2-7-46

RECEIVED

District Health Office No. 2,

District File Number 346-338

Date Filed 3/6/46

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 No Embalming

Licensed Embalmer No.....

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.