

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

FILED JAN 14 1947

State File No. \_\_\_\_\_

Registration District No. 267

Primary Registration District No. 5902

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Lincoln

(b) City or town Rural

(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 10/1/46 years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

(c) City or town Rural

(d) Street No. 3 miles Northwest Hwy-100  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MADISON COOPER

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 31 year 1946 hour 5 minute A. M.

4. Sex male

5. Color or race Col

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

6. (b) Name of husband or wife Callie Cooper

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased: (Month) 3 (Day) 3 (Year) 1887

21. I hereby certify that I attended the deceased from June 1946 to 12-31-46 that I last saw him alive on 12-27-1946 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lobar Pneumonia

Duration \_\_\_\_\_

8. AGE: Years 59 Months 10 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Pope Miss  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation farming

11. Industry or business Cotton farm

12. Name Joe Cooper

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

14. Maiden name Marion Robinson

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

Major findings: Of operations \_\_\_\_\_

Of autopsy 106

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant R. B. Gattner

(b) Address Hwy-100

17. (a) Burial (b) Date thereof 1-5-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hwy-100

18. (a) Signature of funeral director D. D. Smith

(b) Address Hwy-100

19. (a) 1-6-47 (b) D. K. Kelley  
(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) \_\_\_\_\_

(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 J. M. Peters (M.D. or other) \_\_\_\_\_

Address Hwy-100 Date signed 12-31-46

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1-47-22 -

JAN 20 1942  
FEB 3 1942

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 *Hedg. Smith*

Licensed Embalmer No. *4408*

P. O. Address *7047 1/2 City St. Lexington, Va*

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.