

V. S. No. 2
FORM-5-43
Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 31 1947

UNITED STATES BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8842

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 46

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

1. PLACE OF DEATH:

(a) County Hawell

(b) City or town West Plains
(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 _____ (Specify whether)

years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Hawell

(c) City or town West Plains
(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 _____

3. (a) PRINT FULL NAME Gas Carroll Cooper

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced 9

6. (b) Name of husband or wife Alice Russell Cooper

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

7. Birth date of deceased 4 8 1862
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 25
year 1947 hour 6 minute 48 P.M.

21. I hereby certify that I attended the deceased from 2-19 1947 to 2-25 1947
that I last saw him alive on 2-19 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Flu

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>10</u>	<u>17</u>	hr. _____ min. _____

Due to _____

Due to _____

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

10. Usual occupation Farmer

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

Major findings: 33B

11. Industry or business _____

12. Name unk. Cooper

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

14. Maiden name unk.

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

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant G. R. Cooper

(b) Address La Como, Mo

17. (a) B (Burial, cremation, or removal) (b) Date thereof 3-9-47
(Month) (Day) (Year)

(c) Place: burial or cremation Army Cemetery

18. (a) Signature of funeral director Robertson

(b) Address West Plains, Mo

19. (a) Mar 18 - 47 (Date received local registrar) (b) Beatrice Cook (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 0

23. Signature V. B. Roe (M. D. or other) Dr. Q. B. Roe

Address Viola, Ark. Date signed _____

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(Licensed Embalmer's Statement on Reverse Side)

Dr. Q. B. Roe

RECEIVED

District Health Officer No. 5,

District File Number 347160

Date Filed 3-28-47

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.....

Robert J Drago....., Registered Apprentice No. 432,
working under my personal supervision.

Signed Paige J Robertson.....

Licensed Embalmer No. 3432

P. O. Address Nest Plains, 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.