

No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 7 1947 18

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35619
10047
Registrar's No.

Registration District No. 1003 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(c) Name of hospital or institution: Barnes Hospital, O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ralph John Cooper
3. (b) If veteran, name war No
3. (c) Social Security No. Unknown

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Georgena Cooper
6. (c) Age of husband or wife if alive 22 years
7. Birth date of deceased April 15 1925
(Month) (Day) (Year)

8. AGE: Years 22 Months 6 Days 15
If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business

12. Name Earl James Cooper
13. Birthplace Harrison Co. Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Ollie Jane Hildebrand
15. Birthplace Texas Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Roy E. Cooper
(b) Address Palace, Mo.

17. (a) Burial (b) Date thereof 11-2-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Licking, Mo.

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) OCT 30 1947 (Date received local registrar)
O. F. Brueck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Texas 107
(c) City or town Sherrill
(If outside city or town limits, write "RURAL")
(d) Street No. N.R. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1947 hour 8 minute 45 A.M.
21. I hereby certify that I attended the deceased from September 30
1947 to October 30 1947.
that I last saw him alive on October 30 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Chronic glomerulonephritis	
Due to	
Other conditions: Hypertensive cardiovascular disease and uremia.	
Major findings: Of operations	
Of autopsy: As above	

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?
While at work? (Specify type of place) (e) Means of injury
23. Signature: F. L. Bradley (M. D. REGISTER)
Address: Barnes Hospital, 1 Date signed: 10/30/47

1961 8T 1000

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..... *J. Allen Reppert*

Licensed Embalmer No. *4053*

P. O. Address. *St. Louis*

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.