No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 43787

FILED DEC 22 1947

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2546

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 105 days (Specify whether
In this community 10 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0 0 0

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3033 Laclede Avenue 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME COOPER, KATIE LEE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Negro

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

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

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

7. Birth date of deceased August (Month) 17 (Day) 1916 (Year)

8. AGE: Years 31 Months 3 Days 22 If less than one day hr. min.

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

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Sam Williams 9
13. Birthplace ?? (City, town, or county) ?? (State or foreign country)

MOTHER
14. Maiden name Fannie Farmer
15. Birthplace (City, town, or county) Mississippi (State or foreign country)

16. (a) Informant Hospital Records
(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/47 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Dale

18. (a) Signature of funeral director Howell Fun. Home
(b) Address 2834 Lemhe

19. (a) 12-11-47 (Date received local registrar) (b) Cecil G Sharp MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 9
year 1947 hour 11 minute 05 PM.

21. I hereby certify that I attended the deceased from 8-26-47, 19, to 12-9-47, 19; that I last saw her alive on 12-9-47, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	6 mo. (??)
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

13 b

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Bernard Friedman (M. D. or other) MD.

Address Robert Koch Hospital Date signed 12-10-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

NOV 13 1958

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 Shan. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2832 Grand

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.