

FILED JUL 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20046**

BIRTH NO. _____ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 5562 Registrar's No. 15

1. PLACE OF DEATH a. COUNTY <u>Iron</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>	
b. CITY OR TOWN <u>Rural-Acadia</u>		c. CITY OR TOWN <u>Rural-Acadia</u>	
c. LENGTH OF STAY (in this place) <u>1 yr. 9 months</u>		d. STREET ADDRESS (If rural, give location) <u>1 1/2 miles East on Highway 70</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>The Home for aged Baptists</u>			
3. NAME OF DECEASED a. (First) <u>Myrtle</u>		b. (Middle) _____ c. (Last) <u>Cooper</u>	
(Type or Print)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 21, 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>April 1, 1869</u>
9. AGE (in years last birthday) <u>81</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Her Home</u>
11. BIRTHPLACE (State or foreign country) <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Thomas Allen</u>		13b. MOTHER'S MAIDEN NAME <u>Ruth Ellen Whitaker</u>	
14. NAME OF HUSBAND OR WIFE <u>W. R. Cooper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>J. R. Burney</u>		ADDRESS <u>Fronton, Mo</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc.: It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>terminal bilateral bronchial pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Multiple traumas from fall</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>	
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		5-26-50	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Acadia Iron Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 26 1950</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>Patient fell in hall</u>			
22. I hereby certify that I attended the deceased from <u>5-26</u> , 19 <u>50</u> , to <u>6-21</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>5-26</u> , 19 <u>50</u> , and that death occurred at <u>9:20 Am.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>R. E. Harland M.D.</u>		23b. ADDRESS <u>Fronton, Mo</u>	
23c. DATE SIGNED <u>6-21-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-21-50</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Kenners City, Mo</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>June 28, 1950</u>		REGISTRAR'S SIGNATURE <u>Mrs. Aris Jones</u> <u>128</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>White Funeral Home</u>		ADDRESS _____	

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

04770

Rec. 7-1-50
Dist. #6

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Parcel J. White

Licensed Embalmer No. 3012

P. O. Address Director No

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.