

FILED AUG 4 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 23732  
Registrar's No. 298

BIRTH NO. 50107-50 REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give town) Independence		c. CITY (If outside corporate limits, write RURAL and give township) Independence	
c. LENGTH OF STAY (In this place) 6 days		d. STREET ADDRESS (If rural, give location) 818 1/2 South Forest St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Independence Sanitarium			

3. NAME OF DECEASED a. (First) Larry b. (Middle) Dean c. (Last) Cooper			4. DATE OF DEATH (Month) (Day) (Year) 7-26-1950		
5. SEX Male		6. COLOR OR RACE White		8. DATE OF BIRTH July 20, 1950	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant		9. AGE (In years last birthday) 6		10. KIND OF BUSINESS OR INDUSTRY none	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Independence, Missouri.		12. CITIZEN OF WHAT COUNTRY? usa	

13a. FATHER'S NAME Johnny R. Cooper		13b. MOTHER'S MAIDEN NAME LaWanda McKay		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Johnny R. Cooper Indep. Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized peritonitis			7670
		ANTECEDENT CAUSES			
		MORBID CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.			
		DUE TO (b) Peri-umbilical cellulitis			
		DUE TO (c) none			
		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death.			

21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE Edward B. Price Jr. M.D.		23b. ADDRESS General Hospt. K. C. Mo.		23c. DATE SIGNED July 26/50	
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24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE July 27/50		24c. NAME OF CEMETERY OR CREMATORY Neodesha Kansas Cem.		24d. LOCATION (City, town, or county) (State) Neodesha Kansas	
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DATE REC'D BY LOCAL REG. July 27, 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Roland R. Speaks Funeral Home		ADDRESS Independence, Mo	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *Edward T. [Signature]*

Licensed Embalmer No. *3604*

P. O. Address *Indep. 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.