

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9244**

FILED APR 5 1954

BIRTH NO. _____ REG. DIST. NO. 174 PRIMARY REG. DIST. NO. 3035 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lexington</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Lexington</u>	
c. LENGTH OF STAY (In this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>Goodloe Rest Home</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lexington Memorial Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Urmanine</u>	b. (Middle)	c. (Last) <u>Cooper</u>	4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>8</u>	(Year) <u>1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 15, 1864</u>	9. AGE (In years last birthday)	Months <u>89</u>	Days <u>2</u>	Hours <u>23</u>	Minutes
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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>own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Shelby County, Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Not Known</u>	13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	14. NAME OF HUSBAND OR WIFE <u>James R. Cooper</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John W. Cooper, Kansas City, Mo.</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial pneumonia</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive heart failure.</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>4341</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3/6/54, 1954, to 3/8/54, 1954, that I last saw the deceased alive on 3/8, 1954, and that death occurred at 2:50A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ben H. Brasher, M.D.</u>	23b. ADDRESS <u>Lexington, Mo.</u>	23c. DATE SIGNED <u>3/10/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>March 9, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Not Known</u>	24d. LOCATION (City, town, or county) (State) <u>Columbus, Kansas.</u>
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DATE REC'D BY LOCAL REG. <u>3-30-54</u>	REGISTRAR'S SIGNATURE <u>Minna E. Eastabrook</u>	EMERALD DIRECTOR'S SIGNATURE <u>Forest F. Tempel</u>	ADDRESS <u>Lexington, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

No. 300
10.48

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

Boas

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 _____

L. W. McKeane

Licensed Embalmer No. _____

2983

P. O. Address _____

Springton, Missouri

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.