

FILED APR 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12616**

05-92

BIRTH NO. _____		REG. DIST. NO. 187		PRIMARY REG. DIST. NO. 3040		Registrar's No. 120	
1. PLACE OF DEATH a. COUNTY Livingston				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY Livingston, MO.			
b. CITY OR TOWN Chillicothe		c. LENGTH OF STAY (in this place) 28 yr		c. CITY OR TOWN Chillicothe MO 92			
d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hospital				d. STREET ADDRESS (If rural, give location) 104 Lilly St.			
3. NAME OF DECEASED (First) Fannie (Middle) Ophelia (Last) Cooper			4. DATE OF DEATH (Month) (Day) (Year) 4-16-54				
5. SEX F	6. COLOR OR RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2-1-1924		9. AGE (In years last birthday) 30	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Mo. Tipton		12. CITIZENSHIP OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Bowman		13b. MOTHER'S MAIDEN NAME Barbara Anderson		14. NAME OF HUSBAND Clonzo Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Chillicothe Clonzo Cooper no			
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) Cardiac arrest					INTERVAL BETWEEN ONSET AND DEATH 2 minutes
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Uremia					2 weeks
		DUE TO (c) Chronic glomerulonephritis Unknown					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema					6 hours
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 592 X					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.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Chillicothe Livingston, MO			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 April 2, 1954 to April 16, 1954 ; that I last saw the deceased alive on April 16, 1954 ; and that death occurred at 11:25 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) William R. Fair, M.D.				23b. ADDRESS Chillicothe, MO		23c. DATE SIGNED April 17, 1954	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4-19-54	24c. NAME OF CEMETERY OR CREMATORY South Cem.		24d. LOCATION (City, town, or county) (State) Chillicothe MO		
DATE REC'D BY LOCAL REG. 4-17-54		REGISTRAR'S SIGNATURE Frances B. Nead		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. Beckett Chillicothe MO			

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

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 *E. Beckett*

Licensed Embalmer No. 3227

P. O. Address Chillicothe, 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.