

FILED AUG 11 1954

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24400**  
Registrar's No. **7092**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>25 1231 North 9th (rear) 225/2</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frank</b>		b. (Middle) _____	c. (Last) <b>Cooley</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 27, 1954</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>9-11-1895</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>Duncan, Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>Frank Cooley</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Elnora Cooley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Elnora Cooley</b> ADDRESS <b>1231 R. N. 10th St.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Thrombocytopenia purpura (Secondary) Etiology</b>  ANTECEDENT CAUSES <i>Marbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>				INTERVAL BETWEEN ONSET AND DEATH <b>Undt</b>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____			
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? <b>296x</b>			
22. I hereby certify that I attended the deceased from <b>May 17, 1954</b> , to <b>July 27, 1954</b> , that I last saw the deceased alive on <b>July 27, 1954</b> and that death occurred at <b>3:00 a.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>Earl Belle Smith M.D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>7/28/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Aug. 2, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Saint Louis County, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>JUL 30 1954</b>	REGISTRAR'S SIGNATURE <b>Earl Belle Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Metropolitan Funeral System, INC.</b> ADDRESS <b>5010 North</b>			

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.....  
Signature of Student Embalmer

Signed *Paul V. Freeman*

Licensed Embalmer No. *4686*  
P. O. Address *4729 Haru*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.