

Health, Welfare, Public Service, 00, -56, diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED AUG 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24006
STATE FILE NUMBER

Registration District No. 93 Primary Registration District No. 5345 Registrar's No. 57-48

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sac twp.</u>		c. CITY OR TOWN <u>Arcola</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 mi NE Arcola</u>		d. STREET ADDRESS (If outside, give location) <u>R. F. D.</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay in 1b <u>3 yrs.</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Dewey</u> <u>Cooper</u>			4. DATE OF DEATH <u>July 19, 1957</u>		
5. SEX <u>M.</u>			6. COLOR OR RACE <u>W.</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Feb. 22, 1900</u>		
9. AGE (In years last birthday) <u>57</u>			IF UNDER 1 YEAR Months <u>57</u> Days <u>57</u> Hours <u>57</u> Min. <u>57</u>		IF UNDER 24 HRS. Hours <u>57</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Dade County, Mo.</u>	
13. FATHER'S NAME <u>B. F. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Jane Killings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>500-09-3068</u>		17. INFORMANT <u>Ira Cooper; R.F.D. Arcola, Mo.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>since childhood</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pneumatic heart valvular disease</u> DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____		

21. I attended the deceased from <u>12-1-57</u> to <u>7-6-57</u> and last saw ^{her} <u>him</u> alive on <u>7-6-57</u> Death occurred at <u>6:00</u> a. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm. B. Richter, M.D.</u> (Degree or title)		22b. ADDRESS <u>Stockton, Mo.</u>	22c. DATE SIGNED <u>7-24-57</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>July 21, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fullington Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Dade County, Mo.</u>
---	--------------------------------	---	---

24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>7-23-57</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>
--	---	---

(Licensed Embalmer's Statement on Reverse Side)

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 *J. C. Canada*

Licensed Embalmer No. 41

P. O. Address *Greenfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.