

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39171
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 444

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>BOONE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BOONE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only), OR TOWN <u>COLUMBIA</u>		c. CITY OR TOWN <u>COLUMBIA</u> <u>010</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BOONE CO. HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>LENDIR MEMORIAL HOME</u>	
Length of stay in 1b <u>6 YRS.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: <u>ANNIE</u> Middle: Last: <u>COOPER</u>		4. DATE OF DEATH Month: <u>12</u> Day: <u>4</u> Year: <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>1870</u> <u>3-15-1870</u>
9. AGE (In years last birthday) <u>87</u>		9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>USA.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13a. FATHER'S NAME <u>Hudson</u>	
13b. MOTHER'S MAIDEN NAME <u>Hudson</u>		14. NAME OF HUSBAND OR WIFE <u>LEWIS P. COOPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>L. N. Cooper (son) Irving, Texas</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>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Arteriosclerosis</u>			<u>unknown</u>
DUE TO (c) <u>Arteriosclerosis Generalized</u>			<u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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: Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>7-10-51</u> to <u>12-4-57</u> and last saw her alive on <u>12-3-57</u> Death occurred at <u>2:45</u> A. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (D, free or title) <u>Charles M. Lanke M.D.</u>		22b. ADDRESS <u>Columbia, Missouri</u>	22c. DATE SIGNED <u>12-4-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-3-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Confederate</u>	23d. LOCATION (City, town, or county) (State) <u>Higginville Mo</u>
24. FUNERAL DIRECTOR <u>Parker Funeral Service</u>		ADDRESS <u>Columbia</u>	25. DATE RECD. BY LOCAL REG. <u>Dec 4 1957</u>
		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 

Licensed Embalmer No. 5010.....

P. O. Address Columbia, S.C......

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.