

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014604

STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 130 Primary Registration District No. 5573 Registrar's No. 86

Health,
Welfare
Public
Service

300
1-56

7000
All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP <u>TWP</u> OR <u>Buckner-Sni A Bar</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Buckner RFD</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7 Miles South</u> Length of stay in lb <u>40 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>7 Miles South</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>J</u> Last <u>Cooper</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12-1892</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</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>Owner</u>		11. BIRTHPLACE (City and state or country) <u>Carrolton Mo</u>	
13. FATHER'S NAME <u>Mark Cooper</u>			12. CITIZEN OF WHAT COUNTRY? <u>Usa</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			14. MOTHER'S MAIDEN NAME <u>Emma Wilds</u>		17. INFORMANT <u>Anna Cooper</u> Address <u>Buckner Mo</u>
16. SOCIAL SECURITY NO. <u>497-36-4158</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>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>—</u>	
	DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <u>4201</u>		19. WAS AUTOPSY PERFORMED? <u>2</u> 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.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year a. m. <u>—</u> p. m. <u>—</u>		

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.) <u>—</u>	20f. CITY, TOWN, OR LOCATION <u>—</u> COUNTY <u>—</u> STATE <u>—</u>
21. I attended the deceased from <u>em 4-11-58</u> , to <u>em 4-11-58</u> and last saw <u>him</u> alive on <u>4-11-58</u> Death occurred at <u>5AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Valencia Owen MD</u> (Degree or title)	22b. ADDRESS <u>Oak Grove MO</u>	22c. DATE SIGNED <u>4/17/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-15-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cem</u>	23d. LOCATION (City, town, or county) (State) <u>R.F.D. Independence Mo</u>
24. FUNERAL DIRECTOR <u>Webb Funeral Home</u> ADDRESS <u>Blue Springs Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-15-1958</u>	26. REGISTRAR'S SIGNATURE <u>J. B. Langford</u>

APR 22 1958

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 *R. B. Webb*.....

Licensed Embalmer No. *230*

P. O. Address *Blue Springs*.....

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