

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-026855

STATE FILE NUMBER

FILED AUG 1 1958

Registration District No. 318 Primary Registration District 1003 Registrar's No. 7135

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN ST LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION IN ROUCHT CITY H. #1				Length of stay in lb #1 219		d. STREET ADDRESS (If outside, give location) 1823 OFALLON	
3. NAME OF DECEASED (Type or print) First Middle Last Johnnie B Cooper			4. DATE OF DEATH Month Day Year 7 17 58				
5. SEX M 2	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 20 1920		9. AGE (In years last birthday) 37 9 27 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) LABORER			10b. KIND OF BUSINESS OR INDUSTRY CITY REFUSE		11. BIRTHPLACE (City and state or country) ARK.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Johnnie B Cooper				14. MOTHER'S MAIDEN NAME SENNIE ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Bettie J. Cooper 1823 Ofallon			
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 Failure (Heart)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. 4341 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 checked="" type="checkbox"/> NO <input 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 a. m. Month, Day, Year p. m.							
20d. INJURY OCCURRED WHILE AT WORK <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 _____ to _____ and last saw her/him alive on _____ Death occurred at <u>12:50 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>John D. Turner</u> 3				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 7/18/58	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 7-22-58	23c. NAME OF CEMETERY OR CREMATORY NATIONAL C.C.M.		23d. LOCATION (City, town, or county) (State) JEFFERSON BK. MO		
24. FUNERAL DIRECTOR A.F. WALTON 2707 Stoddard			25. DATE RECD. BY LOCAL REG. JUL 19 58		26. REGISTRAR'S SIGNATURE Earl Smith		

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... *Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *4575 A*

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.