Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-035351

STATE FILE NUMBER

FILED NOV 12 1958 Registration District No. 4 Primary Registration District No. 5023 Registrar's No. 88

1. PLACE OF DEATH a. COUNTY Atchison	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Atchison /
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Clay Twsp. Inside Limits Yes ☐ No ☒	c. CITY OR TOWN Clay Twsp. Inside Limits Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) none Length of stay in 1b none	d. STREET ADDRESS (If outside, give location) 0030 none Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print)	First Winnie	Middle Oakman	Last Cooper	4. DATE OF DEATH	Month 11 Day 3 Year 1958
5. SEX Female /	6. COLOR OR RACE White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH 3-16-1901	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 7 Days 17 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Atlanta, Nebr., /	12. CITIZEN OF WHAT COUNTRY? US		
13a. FATHER'S NAME Frank Oakman	13b. MOTHER'S MAIDEN NAME Lillie McDougal	14. NAME OF HUSBAND OR WIFE Willie Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none	16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs Agnes Moulder, Rock Port. Mo.,			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Coronary Occlussion

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 4201

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 ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION Clay Twsp. COUNTY Atchison STATE Mo.,

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____

Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Dr. L. Gallup (Degree or title) Coroner 3	22b. ADDRESS Rock Port, Mo.	22c. DATE SIGNED 11-4-58	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-7-1958	23c. NAME OF CEMETERY OR CREMATORY Hunter Cemetery	23d. LOCATION (City, town, or county) (State) Rock Port. Mo.,
24. FUNERAL DIRECTOR ADDRESS Bartholomew Mortuary, Rockport. Mo	25. DATE RECD. BY LOCAL REG. Nov 6, 1958	26. REGISTRAR'S SIGNATURE Marvin H. Schaeler	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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.

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MAR 26 1955

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 Gratz Buchstaller

Licensed Embalmer No. 3173

P. O. Address Rock Port Mo.

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.