

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041424

STATE FILE NUMBER

FILED NOV 20 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10142

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 5463 Vera Ave.
3. NAME OF DECEASED (Type or print) First Middle Last Thomas B. Cooper		4. DATE OF DEATH Month Day Year Oct. 21 1958	
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1868
9. AGE (In years, give birthday) 89		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	11. BIRTHPLACE (City and state or country) St. Louis, Mo. <input checked="" type="checkbox"/>
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Cooper	
14. MOTHER'S MAIDEN NAME Unknown		15. NAME OF HUSBAND OR WIFE	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. none	18. INFORMANT Allen Cooper 5463 Vera Ave.
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bacterial pneumonia</i> DUE TO (b) <i>Fracture of Left Hip</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. TYPE OF INJURY OCCURRED. (E.g., fall, fire, etc.) <i>fall from chair</i>	
20c. TIME OF INJURY Hour Month, Day, Year <i>8:30 a.m. 9-27-58</i>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20e. CITY, TOWN, OR LOCATION <i>St. Louis Mo</i>		20f. COUNTY STATE	
21. I attended the deceased from Death occurred at <i>2:05</i> to _____ and last saw her/him alive on _____ P. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <i>James M Kelly Deputy</i>	
22b. ADDRESS <i>1300 Clark</i>		22c. DATE SIGNED <i>10-23-58</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-24-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis, County Mo.</i>
24. FUNERAL DIRECTOR Chas. F. Stuart 1225 Union Blvd.		25. DATE RECD. BY LOCAL REG. <i>Oct 23 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith mo</i> <i>mo</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

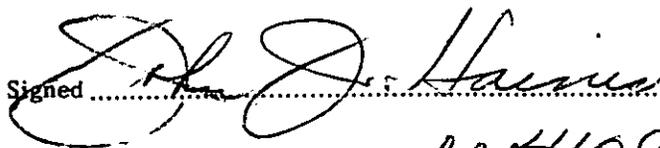
circles in Part I must be causally related.

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. 1274108

P. O. Address:

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.