Health, Welfare Public Service

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FILED FEB 10 1959

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002834
STATE FILE NUMBER

XC-
SL 18788 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 487

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY SAINT CLAIR
b. CITY OR TOWN 915 N.GRAND,ST.LOUIS, MO. Inside Limits Yes [X] No [ ]	c. CITY OR TOWN 512 S. E. ST. LOUIS Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) VET.ADM. HOSPITAL Length of stay in 1b 2 days	d. STREET ADDRESS (If outside, give location) 2107 GATY Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
ISIAH		COOPER	JANUARY 14, 1959

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
MALE	NEGRO	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	5/8/97	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
CUSTODIAN		LAUREL, MISSISSIPPI	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
ABE COOPER	CLAR.	PEARL COOPER

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
YES	WW-1	335-10-5842	VA HOSP. RECORDS, ST. LOUIS, MO.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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)	CEREBRAL VASCULAR HEMORRHAGE	2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	ARTERIOSCLEROSIS	-
DUE TO (c)	- - 331X -	-

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

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19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ] NONE [ ]

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 COUNTY STATE

21. I VA attended the deceased from 1/12/59, to 1/14/59 and last saw him alive on 1/14/59

Death occurred at 2:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Leo T. Neu	M.D.	VAH, ST. LOUIS, MO.	1/14/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	1/19/59 LEO T. NEU, JR., M.D.	National Cemetery	Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Memorial Office	2114 Mo. Ave. St. Louis, Ill.	JAN 15 59	Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

oem

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 Frank Prokopf

Licensed Embalmer No. 4356

P. O. Address St Louis

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.