

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013106

STATE FILE NUMBER

Registration District No. 140 Primary Registration District No. 3024 Registrar's No. 33

S. 300
v. 1-57

1. PLACE OF DEATH
a. COUNTY Howard

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Pike

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fayette Inside Limits Yes No

c. CITY OR TOWN Louisiana 0721 Inside Limits Yes No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Length of stay in 1b

d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First GRIMES Middle LEWELLEN Last COOPER

4. DATE OF DEATH Month Apr. Day 10 Year 1959

5. SEX Male 6. COLOR OR RACE White 7. MARRIED NEVER MARRIED WIDOWED DIVORCED 8. DATE OF BIRTH Mar. 3, 1889 9. AGE (In years birthday) 70 IF UNDER 1 YEAR Months 1 Days 7 IF UNDER 24 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done (If not working, give last occupation if retired)) Retail Merchant 10b. KIND OF BUSINESS OR OCCUPATION Shoe Store 11. BIRTHPLACE (City and state or country) Paris, Mo 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME David Lewellen Cooper 13b. MOTHER'S MAIDEN NAME Belle Grimes 14. NAME OF HUSBAND OR WIFE Nan Burgwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 490-05-3870A 17. INFORMANT Mrs Grimes L. Cooper Address Fayette, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic 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) Insomnia

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES NO

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 Month, Day, Year a.m. p.m.

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 attended the deceased from 2-28-59 to 4-3-59 and last saw her alive on 4-3-59
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) Iva Bloom M.D. 22b. ADDRESS Fayette Mo 22c. DATE SIGNED 4-3-59

23a. BURIAL, CREMATION, CREMATION 23b. DATE 4/12/59 23c. NAME OF CEMETERY OR CREMATORY Elmwood Crematory 23d. LOCATION (City, town, or county) (State) Kansas City, Mo

24. FUNERAL DIRECTOR Kayla A. Carr ADDRESS Fayette, Mo 25. DATE RECD. BY LOCAL REG. 4-3-59 26. REGISTRAR'S SIGNATURE Mary L. Shell

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 16 1959

OCT 16 1959

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, ~~as by~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Ralph A. Carr*

Licensed Embalmer No. *3340*

P. O. Address *Jayette 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.