THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-013234

STATE FILE NUMBER

FEB APR 20 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1695

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 3517 Garner — Length of stay in 1b 40 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 3517 Garner — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Della Middle Frances Last Cooper

4. DATE OF DEATH Month April Day 2 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH April 3-1874
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) Forest Home, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Curtis Mitchell
13b. MOTHER'S MAIDEN NAME Jane —
14. NAME OF HUSBAND OR WIFE Charles R. Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Marie Davis Address 3517 Garner K.C. 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) Arteriosclerotic Heart Disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200

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

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 (Degree or title) Hugh H Owens Coroner
22b. ADDRESS 1034 Rialto Bldg
22c. DATE SIGNED 4-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 4/4/1959
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.
23d. LOCATION (City, town, or county) Kansas City (State) Kansas

24. FUNERAL DIRECTOR C. H. Blackmant Son Inc. ADDRESS K.C. Mo.
25. DATE RECD. BY LOCAL REG. 4-3-59
26. REGISTRAR'S SIGNATURE Neva Minshall

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Hugh H. Owens

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed ....Bert B. Benne

Licensed Embalmer No. 4656

P. O. Address ....R. C., N

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.