

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 23 1960

-60-030893

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 389

ENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Ja.	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 38 yrs	c. CITY OR TOWN Independence
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Indep, Hospt.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 832 S Crysler
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First SAMUEL Middle V Last COOPER			4. DATE OF DEATH Month Aug Day 11 Year 60			
5. SEX Male	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 June 21 1879	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Black smith	11. BIRTHPLACE (City and state or county) Olathe Kan.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Samuel H. Cooper		13b. MOTHER'S MAIDEN NAME Margaret Small		14. NAME OF HUSBAND OR WIFE Mary E. Cooper		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 492-36-6427	17. INFORMANT Mrs Zeanith Webb Address Indep. 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) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 wks
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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) Was a normal sleep. Became confused and lost all memory of last event.
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 **8-4-60** to **8-11-60** and last saw her/him alive on **8-10-60**
Death occurred at **8-11-60** on the date stated above, and to the best of my knowledge from the causes stated.

22. SIGNATURE (Degree or title) John P. Green M.D.		22b. ADDRESS 1590 Wimmer Rd Independence Mo		22c. DATE SIGNED 8-13-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/13/60	23c. NAME OF CEMETERY OR CREMATORY Salem Cem.	23d. LOCATION (City, town, or county) (State) Jackson County	
24. FUNERAL DIRECTOR Old + Mitchell ADDRESS Indep. Mo		25. DATE RECD. BY LOCAL REG. 8-13-60	26. REGISTRAR'S SIGNATURE James D. Craig	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 3156

P. O. Address Quincy

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.