

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044500

VS. DEC 1 1960

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 3302

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u> <u>ST. LOUIS COUNTY</u>		Length of stay in 1b <u>2 weeks</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>COUNTY HOSP.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2334 So. 18th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle Last <u>Cooper</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 17, 1879</u>		9. AGE (last birthday) <u>81</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WORKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SALVATION ARMY</u>		11. BIRTHPLACE (City and state or country) <u>Springfield, Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		
13a. FATHER'S NAME <u>Ferdinand Alexander</u>			13b. MOTHER'S MAIDEN NAME <u>Ellenor Parker</u>			14. NAME OF HUSBAND OR WIFE <u>Guy L. Cooper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT Address <u>ALICE DE WARD 2814 TELEGRAPH</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Post-operative necrotizing fasciitis</u> DUE TO (c) <u>Acute gangrenous appendicitis &amp; perforation</u>							INTERVAL BETWEEN ONSET AND DEATH		
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
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.)					
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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 <u>October 29, 1960</u> to <u>November 13, 1960</u> and last saw her <sup>her</sup> <sub>him</sub> alive on <u>November 13, 1960</u> Death occurred at <u>12:15 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>Robert W. ... M.D.</u>				22b. ADDRESS <u>601 S. Brentwood Blvd., Clayton, Mo.</u>			22c. DATE SIGNED <u>11-14-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>Nov. 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo. Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wacker-Heldule 3634 Gravois</u>				25. DATE RECD. BY LOCAL REG. <u>11-14-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. ...</u>			

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 Helix J. Krupin

Licensed Embalmer No. 3497

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.