

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048887

ED VS JAN 19 1961

Registration District No. 220 Primary Registration District No. 5909 Registrar's No. 4

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <i>Permiat</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MO</i> b. COUNTY <i>Permiat</i> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Cassithersville</i> | Length of stay in 1b <i>dit</i> | c. CITY OR TOWN <i>Cassithersville</i> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>SA</i> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <i>Route 1</i> | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |

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|--|-------------------------------|---|--|--|----------------|
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>David Wayne Cooper</i> | | | 4. DATE OF DEATH Month Day Year <i>12-29-60</i> | | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>white</i> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <i>10-29-60</i> | 9. AGE (last birthday) IF UNDER 1 YEAR Months Days Hours Min. <i>32</i> | IF UNDER 24 HR |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <i>Cassithersville MO</i> | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13. FATHER'S NAME <i>Elmer Cooper</i> | | 13b. MOTHER'S MAIDEN NAME <i>Anna Moore</i> | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Name Address <i>Elmer Cooper Cassithersville Mo</i> | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>BRONCHO PNEUMONIA</i> | | INTERVAL BETWEEN ONSET AND DEATH |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <i>MALNUTRITION</i> | |
| | DUE TO (c) | |

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| 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.) | | | |
| 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 _____ to _____ and last saw him alive on *12-29-60*
Death occurred at *5A* m on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <i>Alan Stubin MD</i> | 22b. ADDRESS <i>Countryside MO.</i> | 22c. DATE SIGNED <i>1-8-61</i> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> | 23b. DATE <i>12-29-60</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion</i> | 23d. LOCATION (City, town, or County) (State) <i>Steele MO</i> |
| 24. FUNERAL DIRECTOR <i>Samuel General Home</i> | | 25. DATE RECD. BY LOCAL REG. <i>1-9-61</i> | 26. REGISTRAR'S SIGNATURE <i>Jack W Tipton</i> |

(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 Not Embalmed, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.