

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-011895

XC-5200023 REG.#A-2168

STATE FILE NUMBER

AMENDED ✓

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 579

FILED VS MAR 16 1961

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		Length of stay in 1b 9 DAYS	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADN. HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3540 ITASKA Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JAMES Middle D. Last COOPER			4. DATE OF DEATH Month 2 Day 26 Year 61		
---	--	--	---	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-7-09	9. AGE (last birthday) 52 YEARS	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	-----------------------------------	---	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER	10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	11. BIRTHPLACE (City and state or country) KANSAS CITY, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	---	--

13a. FATHER'S NAME JAMES COOPER	13b. MOTHER'S MAIDEN NAME NANCY QUINN	14. NAME OF HUSBAND OR WIFE HELEN M. COOPER
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWII	17. INFORMANT HELEN M. COOPER ^{Address} 3540 ITASKA ST. LOUIS, MO. (Wife)
--	---

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		INTERVAL BETWEEN ONSET AND DEATH 11 HOURS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) CEREBRAL ARTERIOSCLEROSIS		1 YEAR
	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)		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
---	--	--

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. VA attended the deceased from 2-17-61 to 2-26-61 Death occurred at 7:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE Adelle C. Kempker (Degree or title) M.D.	22b. ADDRESS VET. ADM. HOSPITAL, JEFF. BRKS., MO.	22c. DATE SIGNED 2-26-61
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 3-1-61	23c. NAME OF CEMETERY OR CREMATORY Calvary Cem	23d. LOCATION (City, town, or county) (State) St Louis MO
---	----------------------------	--	---

24. FUNERAL DIRECTOR Street Carroll ADDRESS 4600 Nat Bld	25. DATE RECD. BY LOCAL REG. 2-28-61	26. REGISTRAR'S SIGNATURE John C. Murphy, M.D.
---	--	--

ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF
 DATE AMENDED

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,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed M W Ruter

Licensed Embalmer No. 4865

P. O. Address St Louis 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.