

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

XC-2589981

SL 27678

-62-007915

STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 2213

AMENDED

FILED FEB 28 1962

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>21 DAYS</b>	c. CITY OR TOWN <b>CARBONDALE,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VET ADM HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>704 1/2 STATE ST., P.O. BOX 677</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLEY COOPER</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 22, 1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-10-80</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (City and state or country) <b>CARBONDALE, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>A. R. COOPER</b>		13b. MOTHER'S MAIDEN NAME <b>CATHERINE NEE ROBINSON</b>		14. NAME OF HUSBAND OR WIFE <b>-</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPAW</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT Address <b>MABEL HUDLOW, SEE # 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTROINTESTINAL HEMORRHAGE, MASSIVE</b> DUE TO (b) <b>GASTRIC ULCER</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>BRONCHIAL CARCINOMA, RIGHT 162.1</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) <b>MULTIPLE PULMONARY THROMBO-EMBOLI, BILATERAL</b>				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 checked="" type="checkbox"/> NO <input 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. Month, Day, Year 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. Attended the deceased from <b>2-1-62</b> to <b>2-22-62</b> and last saw <sup>him</sup> him alive on <b>2-22-62</b> Death occurred at <b>1:50 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>William A. Burke</i> (Degree or title) <b>WILLIAM A. BURKE M.D.</b>			22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>2-22-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>2-24-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>CARBONDALE, ILL.</b>		
24. FUNERAL DIRECTOR <i>William Huffman</i>		ADDRESS <i>Carbondale Ill.</i>	25. DATE RECD. BY LOCAL REG. <b>FEB 23 1962</b>	26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

**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 Pat Embalmers, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Joseph J. Kassel

Licensed Embalmer No. 7541

P. O. Address E. H. Lewis

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.