

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-034481
STATE FILE NUMBER

Registration District No. 132 Primary Registration District No. 3021 Registrar's No. 165

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 17 1962

1. PLACE OF DEATH
a. COUNTY GRUNDY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN TRENTON Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION WRIGHT MEMORIAL HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY GRUNDY
c. CITY OR TOWN TINDALL Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First JAMES Middle COOPER Last
4. DATE OF DEATH Month SEPT Day 8 Year 1962

5. SEX MALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced
8. DATE OF BIRTH 4-4-1876 9. AGE (last birthday) 86-5-4 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) FARMER 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) MERCER CO. MO. 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME THOMAS COOPER 13b. MOTHER'S MAIDEN NAME EMELINE MICHAEL 14. NAME OF HUSBAND OR WIFE LILLIE COOPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) NO 17. INFORMANT Address LILLIE COOPER, TINDALL 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) Cardio-Vascular-Respiratory Disease INTERVAL BETWEEN ONSET AND DEATH 1 Year
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK 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 Sept 1st 1962 to Sept 8th 1962 and last saw her alive on Sept 7th 1962
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 (Deputy or title) Clara F. Duffin 22b. ADDRESS Trenton Mo 22c. DATE SIGNED _____
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL 23b. DATE SEPT-10-1962 23c. NAME OF CEMETERY OR CREMATORY HALP ROCK CEMETERY 23d. LOCATION (City, town, or county) HALP ROCK MO
24. FUNERAL DIRECTOR ADDRESS WISE FUNERAL HOME SPICKARD MO 25. DATE RECD. BY LOCAL REG. 9-10-62 26. REGISTRAR'S SIGNATURE Irene Fair

USE BLACK INK OR TYPEWRITER RIBBON

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300 Rev. 4/59
0405
0400
3
4 0
5 1
6
7 0
8 0
9442X
10
11
122-0
131-0

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 Ross Wise

Licensed Embalmer No. 3771

P. O. Address Spickard 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.