

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

62-048944

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3574

FILED JAN 10 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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28120

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON BARRACKS, MISSOURI</u>		Length of stay in 1b <u>393 DAYS</u>	c. CITY OR TOWN <u>ALTON</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>VETERANS ADMIN. HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>905 W. 9th STREET</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILBERT COOPERWOOD</u>			4. DATE OF DEATH Month Day Year <u>12-6-62</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</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>1-13-96</u>
9. AGE (last birthday) <u>66 YEARS</u>		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) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	11. BIRTHPLACE (City and state or country) <u>NEWPORT, ILL.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>JOHN COOPERWOOD</u>	
13b. MOTHER'S MAIDEN NAME <u>ADDIE BRADFORD</u>		14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW-1</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>HUBERT PATTERSON</u>		Address <u>(Nephew) 4357 Maffitt St. Louis, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			<u>4 years</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>DIABETES MELLITUS</u>			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 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. attended the deceased from <u>11-7-61</u> to <u>12-6-62</u> Death occurred at <u>6:10</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>George Rosenberg, M.D.</u>		22b. ADDRESS <u>VET. ADM. HOSP.; JEFF. BRKS., 25, MO.</u>	22c. DATE SIGNED <u>12-6-62</u>
23a. BURIAL, CREMATION, (EMOVA) (Specify) <u>BURIAL</u>	23b. DATE <u>12-10-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>JEFFERSON BARRACKS</u>	23d. LOCATION (City, town, or county) (State) <u>JEFFERSON BKS. MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>THOMAS JACKSON 2741 DICKSON ST.</u>		25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>

**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 Leroy W. Jannister

Licensed Embalmer No. 4523

P. O. Address 4251 Washington

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.