

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001043

STATE FILE NUMBER

Registration District No. 139 Primary Registration District No. _____ Registrar's No. 6

FILED JAN 17 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300 Rev. 4/59
1 0380
2 0380
3
4 0
5 2
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7 1
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10 0
11 039
12 2-2
13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Gentry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Gentry	
b. CITY (If outside corporate limits, give TOWNSHIP only) Albany		Length of stay in lb 8 days	c. CITY OR TOWN Albany Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gentry County Memorial Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 201 W. Harrison Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle ELVIN Last COOPER			4. DATE OF DEATH Month January Day 7 Year 1963
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/10/179
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY building	9. AGE (last birthday) 83 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City, and state or country) Dallas Co., Iowa		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME James Cooper		13b. MOTHER'S MAIDEN NAME Mary Elizabeth Stout	14. NAME OF HUSBAND OR WIFE Ada Combs Cooper
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) unknown		16. SOCIAL SECURITY NO. _____	17. INFORMANT Mrs. Wade Grooms Address Worth, Missouri
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fulminating Septicemia DUE TO (b) Fracture hip DUE TO (c) Senility Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 5 days
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 Albany, Mo. COUNTY _____ STATE _____
21. I attended the deceased from 30 Dec 62 to 7 Jan 63 and last saw him alive on 7 Jan 63 Death occurred at 11:30A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Dr. W. W. Miller</i> (Degree or title) D.O.		22b. ADDRESS Albany, Mo.	22c. DATE SIGNED 1-9-63
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE Jan 9, 1963	23c. NAME OF CEMETERY OR CREMATORY Grandview	23d. LOCATION (City, town, or county) (State) Albany, Missouri
24. FUNERAL DIRECTOR Brooks-Cochell Funeral Home ADDRESS Albany, Mo.		25. DATE RECD. BY LOCAL REG. 1-15-63	26. REGISTRAR'S SIGNATURE <i>Mrs. L. W. Bare</i>

USE BLACK INK OR TYPEWRITER RIBBON

Recd -
1-15-63

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 no _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Donald E. Cochell

Licensed Embalmer No. 4868

P. O. Address Albany, 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.