

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29474-B

JAN 17 1927

1. PLACE OF DEATH

County Barry Registration District No. 29
 Township Shell Knob Primary Registration District No. 5039
 City Shell Knob (No. 505) St. 36 Ward

File No. _____
 Registered No. 36
 St. _____ Ward _____

2. FULL NAME Hedys Cooper

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (if nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fc 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24-26

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 2 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Shell Knob
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER C.C. Cooper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Shell Knob
 (STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Lucie Call

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Arkansas

14. INFORMANT C.C. Cooper
 (Address) Shell Knob Mo

15. FILED Jan 1 28 Mrs H. P. Williams
 REGISTRAR Dpt.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 7 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 1927, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ 9:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

enteritis
intestinal worms
1198
11313
 CONTRIBUTORY (SECONDARY) _____
 (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

() DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Clinical
 (Signed) A. H. Steiman M. D.
 , 19____ (Address) Cassville, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL 10-8-1927
 20. UNDERTAKER Jacinto ADDRESS Cassville
Norm Funeral Service

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATE DEPARTMENT
WASHINGTON, D. C.

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

[The main body of the document is extremely faint and illegible due to poor scan quality. It appears to be a form or a letter with several sections, but the text is not readable.]

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Barry
Township Shell Knob
City (No. _____) _____

Registration District No. 38
Primary Registration District No. 505-1

File No. 4
Registered No. 36
St. _____ Ward _____

2. FULL NAME

Gladys Cooper

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 24 - 1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 2 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Shell Knob
(STATE OR COUNTRY) MO

10. NAME OF FATHER O. C. Cooper

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Shell Knob
(STATE OR COUNTRY) MO

12. MAIDEN NAME OF MOTHER Cassie Call

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Arkansas
(STATE OR COUNTRY) _____

14. INFORMANT O. C. Cooper
(Address) Shell Knob MO

15. FILED 1-23, 1928 Emma Weddington
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 7 1927

17. I HEREBY CERTIFY That I attended deceased from 10-4 to 10-7, 1927 that I last saw him alive on 9.30 P.M., and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

enteritis & intestinal worms

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) D. A. Newman, M. D.
, 19 (Address) Cassville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Painter DATE OF BURIAL 10-8 1927

20. UNDERTAKER Horsine Funeral Service ADDRESS Cassville MO

N. B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

113B

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