

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

Do not use this space.

36749

1. PLACE OF DEATH

County DeKalb
Township Dollar
City (No.) (St.) (Ward)

Registration District No. 259
Primary Registration District No. 5366

File No.
Registered No.

2. FULL NAME Samuel A. Copley

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 22 - 1847

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>83</u>	<u>3</u>	<u>36</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ny

10. NAME OF FATHER Samuel A. Copley

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) ny

12. MAIDEN NAME OF MOTHER Elizabeth Haber

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

14. INFORMANT Sarahy Haber
(Address) Maple Hill mo 8#6

15. FILED 11-18-29 J. D. Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-17-29 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1928 to Oct 23 or 17 1929 that I last saw breath alive on Oct 23 1928 and that death occurred, on the date stated above, at 11-15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF

19. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? W. A. White's acid
(Signed) Public Health M. D.
. 19 (Address) Fairport 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 Fairport DATE OF BURIAL 11-19-29

20. UNDERTAKER Edw. Pattonburg mo ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS SHOULD BE STATED EXACTLY. PHYSICIANS' SIGNATURES SHOULD BE STATED EXACTLY. PHYSICIANS' SIGNATURES SHOULD BE STATED EXACTLY. PHYSICIANS' SIGNATURES SHOULD BE STATED EXACTLY. PHYSICIANS' SIGNATURES SHOULD BE STATED EXACTLY.

1929
1849

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