JUN 4 1928

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

Do not use this space.

6105-A

1. PLACE OF DEATH
County St Clair
Township Jackson
City ..... (No. ..... St. ..... Ward)
Registration District No. 1037
Primary Registration District No. 6012
File No. .....
Registered No. 2

2. FULL NAME Thomas M Copenhaver
(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: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Della D Copenhaver

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 14th 1873

7. AGE: Years 54 | Months 7 | Days 17 | If LESS than 1 day, ..... hrs. or ..... min.

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) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Near Iconium Mo

PARENTS
10. NAME OF FATHER: Samuel Copenhaver
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo
12. MAIDEN NAME OF MOTHER: Nancy Thompson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Missouri

14. INFORMANT ..... (Address) ✓

15. FILED Apr. 18, 1928 L. Garrison REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 27th, 1928, to Feb 1st, 1928 that I last saw him alive on Jan 27th, 1928, and that death occurred, on the date stated above, at 9 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) G. D. Dalglish, M. D
, 19 (Address) Osceola 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: Iconium
DATE OF BURIAL: Feb 3 1928

20. UNDERTAKER: O S Hull Jr
ADDRESS: Osceola Mo

N. B.—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.