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

Do not use this space.

25502

File No. .....

Registered No. 7876

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis, Mo. (No. City Hosp. #2 ..... St. ..... Ward)

2. FULL NAME Aaron Cope

(a) Residence. No. 2220 Lucas St., 21 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Negro	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE OF~~ Belle Cope

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-11-1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	59	1	15	

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

9. BIRTHPLACE (CITY OR TOWN) unknown
(STATE OR COUNTRY) Louisiana

PARENTS

10. NAME OF FATHER Willis Cope

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT A. G. Creath
(Address) City Hospital #2

15. FILED AUG -7 1930 19 [signature] REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-26-1930

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 26, 1930 that I last saw him alive on July 26, 1930, and that death occurred, on the date stated above, at 7:45 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Perforated Gastric Ulcer
1174
1180 (duration) ..... yrs. ..... mos. ..... ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? X-ray, Gastric Analysis

(Signed) W. E. Hampton, M. D.

7-28-1930 (Address) City Hospital #2

*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
Greenwood Cem.	8/7 1930
20. UNDERTAKER C. W. Roberts	ADDRESS 3035 Luca

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

V. S. No. 2.