

SEP 24 1930

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

Do not use this space.

1. PLACE OF DEATH

County Iron
Township Arctia
City London (No. _____)

Registration District No. 391
Primary Registration District No. 4230

File No. 26542
Registered No. 37
St. _____ Ward _____

2. FULL NAME

Polly Copeland
(a) Residence No. Elberton Mo. Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 7 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 1 30

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired
(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) North Carolina

10. NAME OF FATHER Wm Moore

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

12. MAIDEN NAME OF MOTHER Polly Westwood

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

14. INFORMANT Mrs. Frank Hargrove
(Address) Lesterville Mo.

15. FILED 8/7 1930 R. G. Reisch
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 6th 1930

17. I HEREBY CERTIFY, That I attended deceased from 8-3, 1930 to 8-7, 1930 that I last saw her alive on 8-6, 1930 and that death occurred, on the date stated above, at 10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis - 923
Endocarditis - 780
1057A
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY Thrombosis of left popliteal (SECONDARY) (duration) yrs. mos. ds.

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

19. DATE OF OPERATION PRECEDE DEATH? No
WAS THERE AN AUTOPSY No

WHAT TEST CONFIRMED DIAGNOSIS? None
(Signed) Ray Jay, M. D.
8/7, 1930 (Address) Montana 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 Elberton Mo. DATE OF BURIAL 8-8 1930

20. UNDERTAKER G. R. D. Hale & Son ADDRESS Trouton

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.

Copied to file 26542

