

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

Do not use this space.

5850

1. PLACE OF DEATH

County Greene
Township Boone
City Ash Grove (No. _____)

Registration District No. 316
Primary Registration District No. 4191

File No. _____
Registered No. 5
St. _____ Ward _____

2. FULL NAME Martha Florence Coppinger

(a) Residence. No. _____ St., _____ 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. da. (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) married

5A. IF MARRIED, WIDOWED OR DIVORCED THUS FAR OF (OR) WIFE OF Charles Coppinger

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6/3/1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
63 - 8 - 3

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

9. BIRTHPLACE (CITY OR TOWN) Telling Plains
(STATE OR COUNTRY) Iowa

10. NAME OF FATHER Thos Hunt

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

12. MAIDEN NAME OF MOTHER Betty E Rogers

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

14. INFORMANT Fred Coppinger
(Address) Ash Grove Mo

15. FILED 3-6 1933 Dr Charles Orr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) 2/6 1933

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1933 to Feb 6 1933
that I last saw her alive on Feb 6 1933, and that death occurred, on the date stated above, at 3:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Edema
(duration) _____ yrs. mos. hrs

CONTRIBUTORY (SECONDARY) Myocarditis
(duration) _____ yrs. mos. ds. unknown

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) Dr Charles Orr M. D.

2-7-1933 (Address) Ash Grove 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 Ash Grove Cemetery DATE OF BURIAL 2/8 1933

20. UNDERTAKER U. Galt with Ash Grove Mo ADDRESS _____

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.

