

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3790
Registrar's No. 5

Registration District No. 784 Primary Registration District No. 111

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Richmond Heights
(c) Name of hospital or institution: St. Marys
(d) Length of stay: In hospital or institution 5 days
In this community _____
years, months or days

3. (a) PRINT FULL NAME Adelaide Copp
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced divorced
6. (b) Name of husband or wife Ralph
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 3 1871
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 28
If less than one day _____ hr. _____ min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

MOTHER FATHER {
12. Name Tillewein
13. Birthplace Not known Not known
(City, town, or county) (State or foreign country)
14. Maiden name Not known Not known
15. Birthplace Not known Not known
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert B. True
(b) Address 5390 Pershing

17. (a) burial (b) Date thereof 1/4/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation New Picker cemetery

18. (a) Signature of funeral director John Zugmiller & Son
(b) Address 7027 Grand

19. (a) JAN 3 1940 (Date received local registrar)
(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(d) Street No. 5390 Pershing
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Jan day 1st year 1940 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from Oct 26 1938 to Jan 1 1940
that I last saw her alive on Jan 1 1940
and that death occurred on the days and hour stated above.

Immediate cause of death Myasthenia Gravis
Due to ?
Duration 3 yrs
156

Other conditions no other
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(d) Means of injury _____
23. Signature Les Reilly (M. D. or other) MD
Address 8105 Page Blvd Date signed 1/3/40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *C. P. Kidevel*

Licensed Embalmer No. *3877*

P. O. Address *6937⁹ Illinois*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.