

UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 X1951

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.

1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8139

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 462

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland

(c) Name of hospital or institution:
Route #7, Overland, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Thomas Copeland

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louisiana C.W. Copeland

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased June 10th 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>8</u>	<u>24</u>	hr. min.

9. Birthplace St. James, Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Unemployed

12. Name Martin Copeland

13. Birthplace Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Sophino Hazard

15. Birthplace Dont Know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William Copeland

(b) Address 3946 Nat. Bridge

17. (a) Burial (b) Date thereof 3-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James, Mo.

18. (a) Signature of funeral director Prout Ued Co.

(b) Address 3710 N. Grand Blvd.

19. (a) MAR 5 - 1940 (b) R. Meyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St.

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3946 Natural Bridge Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 4
year 1940 hour 7 minute 45 P. M.

21. I hereby certify that I attended the deceased from January 21, 1940
to March 4, 1940
that I last saw him alive on March 3, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death
Palmarian Plema
Ch. Myocarditis
Cholelithiasis

Due to Cholelithiasis

Due to _____

Other conditions Dyspepsia, Prostate
(Include pregnancy within 3 months of death)

Major findings:
Of operations None

Of autopsy _____

Duration
1 day
6 weeks
6 weeks

PHYSICIAN
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) (e) Means of injury

23. Signature Edward H. Stott (M. D. or other) _____
Address 2302 Voluntary St Date signed 3-5-40

1371. Flotti.
2000 Salary
2.80 - 3.80

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 me

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

Signed..... G. A. Smithers
Licensed Embalmer No. 3916
P. O. Address 3710 N. Grand B

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.