DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22461

Registration District No. 651 Primary Registration District No. 4388 Registrar's No. 55

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Pemiscot

(b) City or town Caruthersville (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 200 E. 4th St (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 42 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemiscot

(c) City or town Caruthersville (If outside city or town limits, write "RURAL")

(d) Street No. 200 E. 4th St (If rural, give location)

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

3. (a) PRINT FULL NAME Robert F. Coppage 120

3. (b) If veteran, name war *

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Jessie B. Coppage

6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased November 8, 1874 (Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 28 If less than one day hr. min.

9. Birthplace Trenton, Tennessee (City, town, or county) (State or foreign country)

10. Usual occupation Broker & grainer

11. Industry or business Cotton Broker

FATHER
12. Name Phillip B. Coppage
13. Birthplace (unknown) Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Chester A. Thompson
15. Birthplace (unknown) (City, town, or county) (State or foreign country)

16. (a) Informant Joe Curtis Coppage

(b) Address Caruthersville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/8/40 (Month) (Day) (Year)

(c) Place: burial or cremation Caruthersville, Mo.

18. (a) Signature of funeral director La Forge Und Co

(b) Address Caruthersville, Mo.

19. (a) June 13, 1940 (Date received local registrar) (b) Ada Martin (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6 year 1940 hour 8 minute 00 P. M.

21. I hereby certify that I attended the deceased from May 24, 1940, to June 6, 1940; that I last saw him alive on June 6, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia	4 days
Due to Paralysis	10 days
Due to Essential Hypertension	5 yr?
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations None

Of autopsy None

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other) MD

Address Caruthersville Mo. Date signed 6/13/40

(Licensed Embalmer's Statement on Reverse Side)

7-40-19

82 D

AUG 12 1943

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 J. G. Schauman

Licensed Embalmer No. 4086

P. O. Address Courthouse, Mo.

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.

S. No. 2B
—2-21-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 12461

Registration District No. 551 Primary Registration District No. 4388 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Pemiscot
(b) City or town: Caruthersville Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DEACEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Robert F Coppage

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia N. M. D.

Due to Paralysis Cerebral Hemorrhage

Due to

Other conditions Essential Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

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 C. C. Castles (M.D. or other)
Address Caruthersville Mo Date signed

SUPPLEMENTARY