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17-39
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FILED OCT 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31045**
3608
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kans. City, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Week St. Joseph - Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 Weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Geo. F. Copas

3. (b) If veteran, name war no 3. (c) Social Security No. NO

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Susan E. Copas 6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased January 28 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 7 Days 18 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business 0

12. Name Charley Copas

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

14. Maiden name Elizabeth Vaughn

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

16. (a) Informant Miss Jean Copas

(b) Address 3120 Woodland

17. (a) Removal (b) Date thereof 9-16-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill - Sedalia, Mo.

18. (a) Signature of funeral director Mrs. C. L. Froster

(b) Address 918 Brooklyn Kansas City Missouri

19. (a) Sept. 16, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Pettis
(c) City or town Sedalia
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 16 day 16 year 1940 hour 11:45 minute 2 A.M.

21. I hereby certify that I attended the deceased from June 24-40 to Sept. 16-40
that I last saw him alive on Sept. 16- 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia

Due to Perniciou anemia

Due to _____
Other conditions (Include pregnancy within 3 months of death) 1070

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 William (M. D. or other) _____

Address 10307 Indep. Ave. Date signed 9-16-40

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

E. H. Wine

Licensed Embalmer No.

2520

P. O. Address.....

K. E. 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, fact should be so stated above.