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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2604

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 49

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

3. (a) PRINT FULL NAME Mamie Cope  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife H.A. Cope 6. (c) Age of husband or wife if alive 58 years  
 7. Birth date of deceased Max. unk. 1893 (Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days unk. If less than one day hr. min.

9. Birthplace Butterfield, Barry Co, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Anderson Phillip

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

14. Maiden name Minnie Unknown

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

16. (a) Informant H.A. Cope

(b) Address Jenkins, Mo

17. (a) Reburial (b) Date thereof 1-14-41 (Month) (Day) (Year)

(c) Place: burial or cremation Cassville, Mo

18. (a) Signature of funeral director Ryan Funeral Home

(b) Address Cassville, Mo

19. (a) 1-14-41 (b) W.E. Handley M.D. (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Barry  
 (c) City or town Near Jenkins, Mo (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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1941 hour 9 minute 55 P. M.

21. I hereby certify that I attended the deceased from Jan 9, 1941, to Jan 14, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia  
 Due to Operation for gall stones  
 Due to gall stones  
 Other conditions 12.6  
 (Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings: gall stones present  
 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? at home

23. Signature W. Phillip Smith M.D. (M. D. or other) M.D.  
 Address Springfield, Mo Date signed \_\_\_\_\_

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

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Mail To  
Koon Funeral Home  
Cassville, Mo

**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.....

*Eugene Wood*

....., Registered Apprentice No.....

..... working under my personal supervision.

Signed.....

*Eugene Wood*

Licensed Embalmer No.....

*5804*

P. O. Address.....

*Cassville, 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.**

*X*