

No. 2
4-13-40
5-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

4201

State File No. _____

FEB 14 1941
Registration District No. _____

Primary Registration District No. 101

Registrar's No. 212

96
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Clayton
 (c) Name of hospital or institution: St. Louis County Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 months 4 days
 In this community 15 years
 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Clara Copeland
 (b) If veteran, name war unknown
 (c) Social Security No. unknown

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife John Copeland
 (c) Age of husband or wife if alive ? years
 7. Birth date of deceased Dec. 14 1883
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 1 14 hr. min.

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

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER {
 12. Name Marion Pogue
 13. Birthplace unknown unknown 9
 (City, town, or county) (State or foreign country)
 14. Maiden name Elizabeth Thornton
 15. Birthplace unknown unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant John Copeland

(b) Address 6512 Plymouth, University City

17. (a) burial (b) Date thereof 1-31-41
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director J. O. N. Clark

(b) Address 1125 Hollidaymont Ave

19. JAN 29 1941 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County St. Louis
 (c) City or town University City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 6512 Plymouth Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 28
 year 1941 hour 12 minute 30 P. A. M.

21. I hereby certify that I attended the deceased from 11-24-40
 _____, 19____, to 1-28-41, 19____;
 that I last saw her alive on 1-28-41, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Sclerosis
 Due to Complications following removal of brain tumor (necrosis)
 Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings: Of operations Large brain tumor in left cerebellar region
 Of autopsy _____

Duration
24 hrs
7 yrs

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 [Signature] (M. D. or other) [Signature]
 Address _____ Date signed _____

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.....

A. J. Kelly

Licensed Embalmer No.....

3225

P. O. Address.....

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.