

1. PLACE OF DEATH:

(a) County Atchison
(b) City or town Tarkio Normal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
301-72-19th 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 5 yrs
years, months or days

8. (a) PRINT FULL NAME SALLIE NICHOL COPELAND

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Joseph Copeland 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased October 9th 1949
(Month) (Day) (Year)

8. AGE: Years 88 Months 6 Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Nichol

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

14. Maiden name Sallie Mary Nichol

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

16. (a) Informant A. M. Copeland

(b) Address Tarkio, Mo

17. (a) Burial (b) Date thereof Oct 11 - 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blosswood Iowa

18. (a) Signature of funeral director James Miller

(b) Address Westboro, Missouri

19. (a) Oct - 11 - 41 (b) W. W. Stang
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Atchison

(c) City or town Tarkio
(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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10th
year 1941 hour 12 minute 15 AM.

21. I hereby certify that I attended the deceased from Sept 1 - 1941
to Oct 10 1941

that I last saw him alive on Oct 10 1941
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic myocarditis with cardiac decompensation & senility
Due to _____

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

Major findings: Of operations _____
Of autopsy _____

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 W. W. Stang (M. D. or other) U
Address Tarkio Mo Date signed Oct 10 41

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.....
.....**Scott Tucker**....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Scott Tucker

Licensed Embalmer No. 2824

P. O. Address Westboro, Missouri

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.