

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

JUN 11 1943

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

19301
Do not use this space.

1. PLACE OF DEATH
(a) County Miss Registration District No. 336
(b) Township Spring 25 Primary Registration District No. 6207
(c) City Success (d) Street No. 1 St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Kauldean Copeland
(a) Residence, No. _____ St. (If nonresident, give city or town and State) 0
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 10, 1943

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
— — 5

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. —
9. Industry or business in which work was done, as saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Success, Mo

FATHER
13. NAME Earl Copeland
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hazelton, Mo

MOTHER
15. MAIDEN NAME Opal Blankenship
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hazelton, Mo

17. INFORMANT (ADDRESS) Earl Copeland

18. BURIAL, CREMATION, OR REMOVAL PLACE Cavaness Cem. 5316-43

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smith & Sproull, Licking, Mo

20. FILED 6-3-43 19 Mrs. Callaghan Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-15-43

22. I HEREBY CERTIFY, That I attended deceased from May 13, 1943, to May 15, 1943
I last saw him alive on May 14, 1943 Death is said to have occurred on the date stated above, at 3:30 P.M.
The principal cause of death and related causes of importance were as follows:
Branch Pneumonia Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Robert Ruedell, M. D.
(Address) Licking, Mo

RECEIVED

District Health Officer No. 5,

District File Number 643361

Date Filed 6-8-73

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,

Not Embalmed

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed *Ernest E. Ferguson*

Licensed Embalmer No. *3945*

P. O. Address *Picking 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.

Registration District No. 356

Primary Registration District No. 6207

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Jordan

(b) City or town Rural
(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
in this community _____ years, months or days)

3. (a) PRINT FULL NAME Pauldean Copeland

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 S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 10 1948
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

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) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ Hour _____ minute _____ M.

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

Immediate cause of death Branchio pneumonia (no complications)

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 Lyle K. Randall (M. D. or other) _____

Address Larkburg, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

MOTHER FATHER

Stokli Randall
Secretary, 1930

S-19301