

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

LED AUG 23 1943

Registration District No. 10-128

Primary Registration District No. 2000

Registrar's No. 660

1. PLACE OF DEATH:

(a) County GREENE

(b) City or town Springfield Mo
(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: 39 years In hospital or institution
(Specify whether years, months or days)

In this community 39 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

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

(d) Street No. 311 Kenwood
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME RALPH E COPELAND

3. (b) If veteran, name war Unk. 3. (c) Social Security No. 318-10-3475

4. Sex <u>Male</u>	5. Color of race <u>White</u>	6. (a) Single, widowed, married, divorced <u>Unwed</u>
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6. (b) Name of husband or wife Unk. 6. (c) Age of husband or wife if alive Unk. years

7. Birth date of deceased Nov. 28 1903
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	<u>39</u>	<u>8</u>	<u>16</u>	hr. <u> </u> min. <u> </u>

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

10. Usual occupation Pressman

11. Industry or business

12. Name Olive Copeland

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

14. Maiden name Orilla Kennard

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

16. (a) Informant Jewel Halney

(b) Address 311 Kenwood, Spfld. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1943
(Month) (Day) (Year)

(c) Place: burial or cremation Green Laurel Cem

18. (a) Signature of funeral director W. R. Hargrave

(b) Address Springfield Mo

19. (a) 8-16-43 (Date received local registrar) (b) W. R. Hargrave (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 14 year 1943 hour 2:00 minute P.M.

21. I hereby certify that I attended the deceased from Aug 8 1943 to Aug 14 1943; that I last saw him alive on Aug 14 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of prostate

Due to Abdominal & pulmonary

Due to Cardiovascular

Other conditions
(Include pregnancy within 3 months of death)

Major findings: Of operations 516

Of autopsy

Duration Unk.

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 Robert Glynn (M. D. or other)
Address Springfield, Mo Date signed 8/16/43

WRITE PLAINLY—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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Roy A. Leavin,
Licensed Embalmer No. 1763
P. O. Address Springfield 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