

DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED FEB 25 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7053

State File No. _____

Registration District No. 181

Primary Registration District No. 5411

Registrar's No. 91

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town SPENCER, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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

JULIANN D. COPELAND

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex FEMALE

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Philip-B. Copeland

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

7. Birth date of deceased Nov (Month)

25 (Day) 1860 (Year)

8. AGE:

Years

Months

Days

If less than one day

83

7

hr. min.

9. Birthplace Unknown (City, town, or county)

TENN (State or foreign country)

10. Usual occupation Housewife

11. Industry or business none

12. Name JAMES BILBREG

13. Birthplace Unknown (City, town, or county)

TENN (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN (City, town, or county)

? (State or foreign country)

16. (a) Informant JACK COPELAND

(b) Address BRUNER Mo

17. (a) BURIAL (Burial, cremation, or removal)

(b) Date thereof Dec 4-43 (Month) (Day) (Year)

(c) Place: burial or cremation Union Chapel

18. (a) Signature of funeral director Relley-Ferrell

(b) Address Sec 9 Mo

19. (a) 1-19-43 (Date received local registrar)

1056

(Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas
(c) City or town RURAL SPENCER (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 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 2 year 1943 hour 4 minute PM

21. I hereby certify that I attended the deceased from 1/20 1943 to 12/2 1943
that I last saw her alive on 11/25 1943
and that death occurred on the date and hour stated above.

Immediate cause of death

Cerebral Hemorrhage

Due to Hypertention

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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 2

23. Signature J. E. Blum (M. D. or other) 20
Address Brilliant, Mo Date signed 12/4/43

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

RECEIVED

District Health Officer No. 6,

District File Number 2447260

Date Filed FEB 21 1944

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.....

This Body not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.