

18874

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 7 1944

Registration District No.

Primary Registration District No. 3053

Registrar's No. 63

1. PLACE OF DEATH:

(a) County Rolla, Mo.
(b) City or town Rolla, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Helle McFarlands Memorial Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Crawford
(c) City or town Steelville Mo.
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location) no
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Jerry David Lawrence Coplin

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

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Feb. 19, 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 17 hr. min.

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

10. Usual occupation Infant

11. Industry or business

12. Name Esco Coplin

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

14. Maiden name Laura Medley

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

16. (a) Informant Esco Coplin

(b) Address Steelville Mo.

17. (a) Burial (b) Date thereof 5/7/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wymore Mo.

18. (a) Signature of funeral director L. J. Jones & Son

(b) Address Rolla Mo.

19. (a) 5/6-44 (b) J. E. ...
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th
year 1944 hour 8:12 minute 30 P. M.

21. I hereby certify that I attended the deceased from May 4, 1944 to May 6, 1944
that I last saw him alive on May 6th, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Trauma around shoulder, left arm & chest
Division

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

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) (c) Means of injury

23. Signature A. J. ... (M. D. or other)

Address Rolla, Mo. Date signed 5/6/44

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.

not embalmed

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.

N. 2B
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. June 63
Registrar's No. 63

Registration District No. 275

Primary Registration District No. 3053

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

1. PLACE OF DEATH:

(a) County Phillips
(b) City or town Rolla
(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

Jerry O. L. Caplan

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 Feb. 19 1944
(Month) (Day) (Year)

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

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

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) _____ (b) Date thereof _____ (Burial, cremation, or removal) (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 May day _____ year 1944 hour _____ minute _____ M.

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

Immediate cause of death Stroke around shoulder, left arm to chest
Due to fall (see reverse side)

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) ? See reverse side

(b) Date of occurrence May ?

(c) Where did injury occur? Home Steelville, Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Rolia, Mo. (City or town) (County) (State) Date signed 6-13-44

SUPPLEMENTARY

It was stated by the mother that the baby was pulled from bed by a smaller child of family (two year old baby), and possibly sustained the injury.

A. Sidney McFarland, M.D.

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