

No. 2
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17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3717

State File No.

FILED FEB 18 1945
Registration District No. 575

Primary Registration District No. 4476

Registrar's No. 3

1. PLACE OF DEATH:
(a) County Schuyler
(b) City or town Worring
(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 30 years or more
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State mo (b) County Schuyler
(c) City or town Worring
(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 _____

3. (a) PRINT FULL NAME Clinton Henry Coppers
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 11
year 1945 hour 2 AM minute _____ A.M.
21. I hereby certify that I attended the deceased from Sept 15
1944 to Jan 10 1945
that I last saw him alive on Jan 10 1945
and that death occurred on the date and hour stated above.
Immediate cause of death Cachexia

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife Callie Coppers 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 20 1885
(Month) (Day) (Year)

Due to Hodgskins Disease
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations 44
Of autopsy _____

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>3</u>	<u>21</u>	hr. _____ min.

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

9. Birthplace Hurdland mo
(City, town, or county) (State or foreign country)
10. Usual occupation Retired merchant

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

MOTHER FATHER {
12. Name Henry Coppers
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name Lydna Ruard
15. Birthplace mo (City, town, or county) (State or foreign country)

16. (a) Informant Callie Coppers
(b) Address Worring mo
17. (a) Burial (b) Date thereof Jan 14 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Worring Cemetery
18. (a) Signature of funeral director Loyd Moore
(b) Address Worring mo
19. (a) Jan 18 1945 (b) A. Justice
(Date received local registrar) (Registrar's signature)

23. Signature George W. Johnson (M. D. or other) D.O.
Address Worring Mo. Date signed Jan 17 1945

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

1278

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 10

District File Number 2-45-286

Date Filed FEB 11 1945

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 me

Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Lloyd Moore

Licensed Embalmer No. 3151

P. O. Address Dawning 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.