

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED OCT 16 1946 STANDARD CERTIFICATE OF DEATH**

33487

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4217

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)  
In this community as above 40 years

3. (a) PRINT FULL NAME John Israel Cope  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased: August 18 1881  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
65 1 16 15 hr. min.

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

10. Usual occupation Show Card Writer

11. Industry or business X

MOTHER FATHER {  
12. Name David P. Cope  
13. Birthplace Pennsylvania  
(City, town, or county) (State or foreign country)  
14. Maiden name Jutta E. Pettibone  
15. Birthplace Michigan  
(City, town, or county) (State or foreign country)

16. (a) Informant Susan E. Barnard  
(b) Address Wellsville, Kansas.

17. (a) removal (b) Date thereof 10-3-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Wellsville, Kansas.

18. (a) Signature of funeral director Stim & McClure  
(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 10-5-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
Missouri (a) State Kansas (b) County JACKSON  
(c) City or town Wellsville KANSAS CITY  
(If outside city or town limits, write "RURAL")  
(d) Street No. 801 EAST 12th ST.  
(If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 3  
year 1946 hour 12 minute 55 P.M.  
21. I hereby certify that I attended the deceased from Oct. 1 1946 to Oct. 3 1946  
that I last saw him alive on Oct. 3 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Benign prostatic hypertrophy with bilateral hydronephrosis

Due to .....  
Due to .....  
Other conditions (Include pregnancy within 3 months of death) .....  
Major findings: 137a  
Of operations .....  
Of autopsy .....  
See above

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 Brinden Hull (M. D. or other) 10-3-46  
Address Med. Dir. Gen'l Hosp. Date signed

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

3235

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 Robert H Reed  
Licensed Embalmer No. 3745  
P. O. Address NC 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.**