

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **30194**  
**3974**

|  |  |   |   |   |  |  |   |
|--|--|---|---|---|--|--|---|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>149</u>   |   | PRIMARY REG. DIST. NO. <u>7002</u>  |  | Registrar's No. _____  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>JACKSON</u>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> |  |  |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>KANSAS CITY</u>   |  | c. LENGTH OF STAY (in this place)<br><u>1 1/2 mo.</u>   |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>KANSAS CITY</u>  |  | 3108<br>3300   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>TROOST AVE NURSEING HOME</u>   |  |   |   | d. STREET ADDRESS (If rural, give location)<br><u>2600 ASKEW</u>  |  |  |   |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>OLLIE</u>   |  |   | b. (Middle) <u>COPELAND</u>               |   | c. (Last)  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>9 18 51</u> |
| 5. SEX<br><u>FEMALE</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>WIDOWED</u>  |  | 8. DATE OF BIRTH<br><u>AUG 7-1865</u>                                    |   |
| 9. AGE (In years last birthday)<br><u>86</u>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>HOME</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>ARK 1</u>                |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |   |
| 13a. FATHER'S NAME<br><u>TOM S. SMITH</u>  |  |   | 13b. MOTHER'S MAIDEN NAME<br><u>HODGE</u> |   | 14. NAME OF HUSBAND OR WIFE<br><u>JOE COPELAND</u> |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Max Fay League 2600-Askew</u>   |  |  |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Myocarditis (chr)</u><br>DUE TO (c) <u>Pneumonia a year ago. Ovarian cyst over 12 years</u> |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4201</u>                          |   |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)   |  |  |   |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR?  |  |  |   |
| 22. I hereby certify that I attended the deceased from <u>9-7th</u> , 19 <u>51</u> , to <u>9-18</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>9-17</u> , 19 <u>51</u> , and that death occurred at _____ m., from the causes and on the date stated above. |  |   |   |   |  |  |   |
| 23a. SIGNATURE <u>Amin Boutros M.D.</u> (Degree or title)  |  |   |   | 23b. ADDRESS <u>416 Argyle K.C. Mo</u>  |  | 23c. DATE SIGNED <u>9-18-51</u>  |   |
| 24a. BURIAL, CREMATION, REMOVA (Specify)   |  | 24b. DATE   |   | 24c. NAME OF CEMETERY OR CREMATORY  |  | 24d. LOCATION (City, town, or county) (State)                            |   |
| <u>Burial</u>  |  | <u>9-19-51</u>  |   | <u>MOUNT WASHINGTON</u>   |  | <u>KANSAS CITY Mo</u>  |   |
| DATE REC'D BY LOCAL REG.<br><u>9-18-51</u>   |  | REGISTRAR'S SIGNATURE<br><u>Geraldine Holmes</u>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>John P. Sheil</u>  |  | ADDRESS<br><u>R. E. Mc</u>   |   |

(Licensed Embalmer's Statement on Reverse Side)

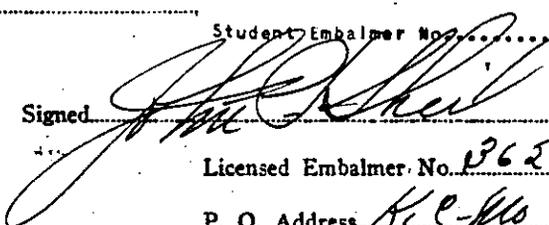
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed  .....

Signed.....  
Student Embalmer

Licensed Embalmer No. 3625

P. O. Address K.C. 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.