

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22783**
Registrar's No. **5782**

FILED JUN 24 1953

318 1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Green, 0341 | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bois Darc, Mo. | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis Childrens Hospital | | | |

| | | | | | |
|---|---------------------------|---|---|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Wayne b. (Middle) LEE c. (Last) Copeland | | | 4. DATE OF DEATH (Month) (Day) (Year) 6-8-53 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) N | 8. DATE OF BIRTH 7-25-01 | 9. AGE (In years last birthday) 1yr. | IF UNDER 1 YEAR: MONTHS _____ DAYS _____ |
| 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) Springfield, Mo. | |
| 13a. FATHER'S NAME John Grant Copeland | | | 13b. MOTHER'S MAIDEN NAME Wilma Friend | | 14. NAME OF HUSBAND OR WIFE |

| | | | | |
|---|-------------------------|-----------------------------------|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME | | ADDRESS |
|---|-------------------------|-----------------------------------|--|---------|

| | | | |
|---|---|--|----------------------------------|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medulloblastoma of brain with metastasis. | | |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

| | | |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? 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) (Min) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 193X |

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **9a**: m., from the causes and on the date stated above.

| | | |
|--|--|--------------------------------|
| 23a. SIGNATURE (Degree or title) Dr. L. Thuroto, M.D. | 23b. ADDRESS Childrens Hospital | 23c. DATE SIGNED 6-9-53 |
|--|--|--------------------------------|

| | | | |
|--|--------------------------|--|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) removal | 24b. DATE 6-10-53 | 24c. NAME OF CEMETERY OR CREMATORY Johns Chapel | 24d. LOCATION (City, town, or county) (State) Ash Grove, Mo. |
|--|--------------------------|--|---|

| | | | |
|---|--|---|-------------------------------|
| DATE REC'D BY LOCAL REG. JUN 10 1953 | REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | 25. FUNERAL DIRECTOR'S SIGNATURE W. Birch, F. N. | ADDRESS Ash Grove, Mo. |
|---|--|---|-------------------------------|

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Derick J. Brown*

Licensed Embalmer No. *4366*

P. O. Address *St. Louis, 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.