

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

8565

State File No. _____

898

BIRTH NO. **FILED MAR 18 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY Jackson	b. CITY OR TOWN Kansas City	a. STATE Mo.	b. COUNTY Jackson
c. LENGTH OF STAY (In this place) 45 yrs.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Menorah Medical Center			
e. STREET ADDRESS (If rural, give location) 640 E 71st Terr.		3910	

3. NAME OF DECEASED			4. DATE OF DEATH		
a. (First) HERMAN	b. (Middle) COPAKEN	c. (Last) COPAKEN	(Month) 2	(Day) 26	(Year) 54
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 4-11-1900		9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Russia	
13a. FATHER'S NAME Morris Copaken			13b. MOTHER'S MAIDEN NAME Sarah (Unknown)		14. NAME OF HUSBAND OR WIFE Dorothy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Mrs. Louis White	
				ADDRESS 1203 W 68th Terr.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Convulsions		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Cancer of the Colon			
		DUE TO (b)			
		DUE TO (c)			
		11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		153X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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 Jan 1952 to Feb 26, 1954, that I last saw the deceased alive on Feb 26, 1954, and that death occurred at 7:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE L. M. Shapiro	23b. ADDRESS 624 Park - Bldg	23c. DATE SIGNED 2-27-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-28-54	24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 2-27-54	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Louis Fun'l Home	ADDRESS K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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.....
Signature of Student Embalmer

Signed..... *Archie Lewis*

Licensed Embalmer No. *3112*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.