

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

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>322</u>		PRIMARY REG. DIST. NO. <u>3071</u>		Registrar's No. <u>95</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>			
b. CITY OR TOWN <u>Slater</u>		c. LENGTH OF STAY IN THIS PLACE (Township) <u>9 Months</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Slater</u>		69710	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>703 East Washington</u>				d. STREET ADDRESS (If rural, give location) <u>703 East Washington</u>			
3. NAME OF DECEASED (Type or Print) <u>SAMMUEL NELSON COPELAND</u>			a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 28 '55</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. BIRTH <u>Nov 28 1885</u>	9. AGE (In years last birthday) <u>70-7-22</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Days	IF UNDER 1 MIN. Hours Min.
10a. USUAL OCCUPATION (Classified of work done during most of working life, e.g., retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agiculture</u>		11. BIRTHPLACE (City and State of Foreign Country) <u>Slater, Saline Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Amos Ben Copeland</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Billey</u>		14. NAME OF HUSBAND OR WIFE <u>Cora Bell Copeland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>498-37-1028</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Cora Bell Copeland</u>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hi Blood Pressure</u>					
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>331X</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>L</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>L</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>L</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>L</u>			
22. I hereby certify that I attended the deceased from <u>July 22, 1954</u> to <u>Dec 27, 1955</u> , that I last saw the deceased alive on <u>DEC 27, 1955</u> , and that death occurred at <u>11</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>R.H. Kuebler DO.</u>				23b. ADDRESS <u>Slater Mo</u>		23c. DATE SIGNED <u>1/2/56</u>	
24a. BURIAL CREMATION REMOVAL (Specify) <u>buried</u>		24b. DATE <u>12-31-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Slater City</u>		24d. LOCATION (City, town, or county) (State) <u>Slater Saline Co Mo</u>		
DATE REC'D BY LOCAL REG. <u>1/3/56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Earl C. Metz</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Jones</u>		ADDRESS <u>Slater Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

FILED JAN 9 1956

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 _____ ✓

working under my personal supervision. ✓ Student Embalmer No. _____ ✓

Student ✓
Student Embalmer

Signed James E. Jones
Licensed Embalmer No. 3143
P. O. Address State, Md

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.