

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17002  
STATE FILE NUMBER

2009  
Registrar's No.

FILED MAY 20 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 2009

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>Jackson</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>KANSAS CITY</b> 138		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>VETERANS ADM. HOSPITAL</b>				Length of stay in 1b) <b>1 year</b>		D STREET ADDRESS (If outside, give location) <b>901 LOCUST, SHERMAN HOTEL</b>		Reside on Farm No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>W.</b> Last <b>COPP</b>			4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1957</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 29, 1892</b>		9. AGE (In years last birthday) <b>64</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer &amp; Cemetery Caretaker - Eudora, Kans.</b>			100. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Eudora, Kansas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Copp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wunders</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>			16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT Address <b>VA Hospital Official Records, K. C. Mo</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinomatosis of abdomen</b> DUE TO (c) <b>Leiomyosarcoma (non-o.)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>197X</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <b>April 18, 1957</b> to <b>April 26, 1957</b> <del>xxxxxxxxxxxxxxxx</del> Death occurred at <b>3:15 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>L. G. AGEE, M.D.</b> <i>L. G. Agee M.D.</i>				22b. ADDRESS <b>VA Hospital, Kansas City, Mo.</b>		22c. DATE SIGNED <b>4/26/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Apr-29-1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EUDORA CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>EUDORA KANSAS</b>			
24. FUNERAL DIRECTOR <b>DIV. NEWCOMER'S SONS</b> ADDRESS <b>1331 BRUSH CREEK KANSAS CITY, MO.</b>			25. DATE RECD. BY LOCAL REG. <b>4-29-57</b>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>				

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



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 *Basil Honey*

Licensed Embalmer No. *H. 72*

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