

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

43035

STATE FILE NUMBER

FILED NOV 22 1957

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2745

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> (Institution)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Spanish Lake</b>		c. CITY OR TOWN <b>Spanish Lake</b> <u>4000</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>11640 Bellefontaine Rd.</b>		d. STREET ADDRESS <b>11640 Bellefontaine Rd.</b>	
Length of stay in 1b <b>1 year</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Orville</b> Middle <b>A.</b> Last <b>Cope</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</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 type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 8, 1884</b>
9. AGE (In years last birthday) <b>73</b>		10. USUAL OCCUPATION (Give kind of work done during year ending life, even if retired) <b>Plastic Worker</b>	11. BIRTHPLACE (City and state or country) <b>Jerseyville, Illinois</b>
10a. USUAL OCCUPATION (Give kind of work done during year ending life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>William Jacob Cope</b>		13b. MOTHER'S MAIDEN NAME <b>Adelaide Patterson</b>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, <b>None</b> ) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>345-07-1689</b>	17. INFORMANT <b>Mr. Dwight Cope</b> Address <b>11640 Bellefontaine Rd</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>Esophageal Occlusion</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Cardio-Vascular disease</b> DUE TO (c) <b>Arterio Sclerosis - 4/20.1</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.			
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 <u>11-2-49</u> to <u>6-26-57</u> and last saw her alive on <u>6-26-57</u> Death occurred at <u>11640 Bellefontaine Rd</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In full name and title) <b>Colonel P. Parker M.D.</b>		22b. ADDRESS <b>6826 Natural Bldg.</b>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Removal via Motor</b>	<b>Nov. 4, 1957</b>	<b>Grimes Cemetery</b>	<b>Jerseyville, Illinois</b>
24. FUNERAL DIRECTOR ADDRESS <b>Math Hermann &amp; Son, Inc. 2161 E. Fair Ave</b> <b>St. Louis, Missouri</b>		25. DATE RECD. BY LOCAL REG. <b>11-5-57</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Domke M.D.</b> <i>asc</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

JAN 3 1958

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 *Walter G. Burnley* .....  
Licensed Embalmer No. *4202* .....  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.