Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-014832
STATE FILE NUMBER

FILED APR 24 1959 Subregistration District No. ..... Primary Registration District No. ..... Registrar's No. 2-3477

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY
b. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) City Hospital — Length of stay in Ib D.O.A.	d. STREET ADDRESS (If outside, give location) 7144 Jamieson Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
MARY	C.	COPPOCK	Apr.	6	1959

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Jan. 27, 1906	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Distriutor-Magic Skin Care		Indiana	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
James Allen	Nettie Cobb	Otis Coppock

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	None	312-07-8262	Otis Coppock	7144 Jamieson Ave.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Emphysema

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Lobar Pneumonia

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 490X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ — 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 ☐ NOT WHILE AT WORK ☐ — 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 ..... to ..... and last saw her/him alive on .....
Death occurred at 8:05 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Patrick J. Taylor	Coroner	1300 Clark	4.8.59.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal (Rail)	4-9-59		Indianapolis, Ind.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Kriegshauser	4228 S.Kingshighway	APR 8 '59	Hoard Smith, M.D. MDC

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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 Richard W. Storzand

Licensed Embalmer No. 4007

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.