

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 7 1958

59-024549

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 3016 Registrar's No. 213

1. PLACE OF DEATH a. COUNTY <u>Cole</u>				2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jefferson City</u>		Length of stay in 1b <u>14 hrs</u>		c. CITY OR TOWN <u>Bland</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chas. Still Hosp</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS and: (If outside, give location) <u>Lincoln Mann Rest Home - Lincoln Mo</u>		Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Marion</u> Last <u>Copeland</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 5 - 1884</u>			
9. AGE (last birthday) <u>74</u>		F UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (City and state or country) <u>Marion County - Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Martin Copeland</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Parker</u>			14. NAME OF HUSBAND OR WIFE <u>Minerva Copeland</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No.</u>			16. SOCIAL SECURITY NO. <u>498-18-5670</u>		17. INFORMANT <u>Jak Copeland - Bland - Mo</u>			Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			DUE TO (b) <u>Medullary Failure</u>				<u>23 hrs</u>		
			DUE TO (c) <u>Cerebrovascular Accident</u>				<u>24 hrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Advanced Age - Arteriosclerosis + Tuberculosis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ e.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 <u>3/13/58</u> to <u>7/31/58</u> and last saw him alive on <u>7/31/58</u>				Death occurred at <u>11:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Will Fellers</u> (Degree or title)				22b. ADDRESS <u>Bland, Mo</u>			22c. DATE SIGNED <u>8/1/58</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>Aug 3 - 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Henner Cemetery</u>		23d. LOCATION (City, town, or county) <u>Marion County - Mo.</u>			
24. FUNERAL DIRECTOR <u>Charles Saseman, Bland Mo</u>				25. DATE RECD. BY LOCAL REG. <u>3 August 1958</u>		26. REGISTRAR'S SIGNATURE <u>R. P. Davis MD-MR</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Cherita Dasm

Licensed Embalmer No. 4178

P. O. Address Blanco

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.