

**PURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS SEP 29 1959**

**59-033696**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 8292**

UNRECORDED

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Wayne</b>			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in lb <b>5 weeks.</b>		c. CITY OR TOWN <b>Leeper</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Chronic Hosp.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS _____		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>Burks</b> Last <b>Copeland</b>				4. DATE OF DEATH Month <b>9</b> Day <b>3</b> Year <b>59</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>4-27-1898</b>	9. AGE (last birthday) <b>61</b>	IF 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) <b>Maintenance Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Christian Hospital</b>		11. BIRTHPLACE (City and state or country) <b>Ellington, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John Logan Copeland</b>			13b. MOTHER'S MAIDEN NAME <b>Gora Burks</b>			14. NAME OF HUSBAND OR WIFE <b>-</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes-1-20-20 to 7-28-21 &amp; 9-4-42 to 2-10-43</b>			16. SOCIAL SECURITY NO. <b>#488-18-4031</b>		17. INFORMANT <b>John Copeland</b> Address <b>Piedmont, Missouri</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>Aquamous Cell C.A. Rt. Lung</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 mths.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						<b>163x</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 _____ 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>7-22-59</b> to <b>9-3-59</b> and last saw her alive on <b>9-3-59</b> Death occurred at <b>11:50 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>			22b. ADDRESS <b>5800 Arsenal</b>			22c. DATE SIGNED <b>9/3/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>		23d. LOCATION (City, town, or county) <b>Piedmont, Missouri</b>			
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc.</b> ADDRESS <b>4700 Washington</b>			25. DATE RECD. BY LOCAL REG. <b>SEP 8'59</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>		

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John Haines

Licensed Embalmer No. 4108

P. O. Address Admission

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.