

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-010301

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4459 Registrar's No. 9

AMENDED DATE AMENDED INSTEAD OF DOCUMENT MEDICAL CERTIFICATION SHOULD READ BY AFFIDAVIT OF ITEM NO.

1. PLACE OF DEATH a. COUNTY St. Clair b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Osceola Length of stay in 1b 1 day c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Osceola Med; Hosp; 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair c. CITY OR TOWN Iconium Inside Limits Yes No Reside on Farm Yes No d. STREET ADDRESS (If outside, give location) 3. NAME OF DECEASED (Type or print) First Middle Last Atha - Halley 4. DATE OF DEATH Month Day Year 2/27/61 5. SEX Female 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 7/3/79 9. AGE (last birthday) 81 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Iconium Missouri 12. CITIZEN OF WHAT COUNTRY USA 13a. FATHER'S NAME Benjamin Copenhaver 13b. MOTHER'S MAIDEN NAME Mary Hudson 14. NAME OF HUSBAND OR WIFE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT John Scott, Iconium Missouri 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) Cerebral Vasculer Accident (cerebral Hemorrhage) DUE TO (b) DUE TO (c) 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. 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 2-27-61 to 2-27-61 and last saw her alive on 2-27-61 Death occurred at 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. 22a. SIGNATURE (Degree or title) 22b. ADDRESS Osceola Missouri 22c. DATE SIGNED 3/1/61 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE 3/2/61 23c. NAME OF CEMETERY OR CREMATORY Iconium 23d. LOCATION (City, town, or county) (State) Iconium MO 24. FUNERAL DIRECTOR ADDRESS Goodrich F: Home, Osceola Mo 25. DATE RECD. BY LOCAL REG. 3-1-61 26. REGISTRAR'S SIGNATURE Ruth Seewers

FEB 28 1969

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 J. B. Baschich

Licensed Embalmer No. 3038

P. O. Address Quincy 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.