

No. 2
-13-40
17-39
X23159

FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **8828**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **2238**

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **Coppage, Rose Etta**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Ben J.** 6. (c) Age of husband or wife if alive **5** years

7. Birth date of deceased **July 15 1884**
(Month) (Day) (Year)

8. AGE: Years **56** Months **7** Days **22** If less than one day hr. min.

9. Birthplace **London, Ind.** (City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **John B. Archibald**

13. Birthplace **Logan Co. / Illinois** (City, town, or county) (State or foreign country)

14. Maiden name **Margaret Ann Jones**

15. Birthplace **Logan Co. / Illinois** (City, town, or county) (State or foreign country)

16. (a) Informant **Pauli Coppage**

(b) Address **Jefferson City, Mo.**

17. (a) **Removal** (b) Date thereof **3/11/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Jefferson City, Mo.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **MAR 10 1941** (b) **J. T. Predeck**
(Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **26 N.R.**
(c) City or town **Jefferson City** **5**
(If outside city or town limits, write "RURAL")
(d) Street No. **618 Madison** **4**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **1** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **9**
year **1941** hour **1** minute **P.M.**

21. I hereby certify that I attended the deceased from **2-28** 19**41**, to **3-9** 19**41**;
that I last saw her alive on **3-9** 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Brain tumor, malignant**

Duration

Due to

Due to

Other conditions. (Include pregnancy within 3 months of death)

Major findings: Of, operations

Of autopsy **Brain tumor, malignant**

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury **D**

23. Signature **J. R. Bradley** (M. D. 255625)
Address **BARNES HOSPITAL** Date signed **3-10-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

709

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Gay W Wilkerson

Licensed Embalmer No.....

3575

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 this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8828

Registrar's No. 2238

Registration District No. 791

Primary Registration District No. 1003

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County St Louis
(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Coppage, Rose Etta

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
56 7 22 hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-29-41 (b) J.F. Bredel
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 3 day 9
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (include pregnancy within 8 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature J.L. Parley (M. D. or other) _____
Address Barnes Hosp Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

