

S. No. 2  
DM-2-43  
5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED NOV 1 1943  
1343/49  
Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 4281

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
5715 Indiana  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether years, months or days)

In this community 66 yrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 5715 Indiana 8  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

3. (a) PRINT FULL NAME Augusta C. Cope

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

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

6. (b) Name of husband or wife Landon Cope 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased August 29 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>1</u>	<u>7</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name George Reck

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

14. Maiden name No Record

15. Birthplace No Record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. J. H. Burnette

(b) Address 5715 Indiana

17. (a) Burial (b) Date thereof Oct 9 - 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Mr. C. R. Foster

(b) Address 718 Broadway

19. (a) 10-8-43 (b) N. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 6th, year 1943 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from Oct 9 1943 to Oct 6 1943 that I last saw him alive on Oct 8 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Cerebral Hemorrhage  
Due to Arteriosclerosis

Other conditions 83a  
(Include pregnancy within 3 months of death)

Major findings: Of operations no  
Of autopsy no

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? \_\_\_\_\_  
(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 Michael White  
Address 734 Ogden St  
(M.D. or other) more signed Oct 19

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

Dr. Myrtle O. Hill

Angyle Beck  
Nov 8/07

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**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.....

Licensed Embalmer No. ....

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.**