

FILED NOV 10 1943 149

Registration District No. 149

Primary Registration District No. 1002

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: General Hospital No. 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 Days  
(Specify whether)

In this community 9 1/2 Months  
years, months or days juanita

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

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

(d) Street No. 2228 Campbell Street  
(If rural, give location) **5**

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

3. (a) PRINT FULL NAME LOVIE COPELAND Washington

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10- day 23-  
year 1943 hour 5: minute 10 A.M.

21. I hereby certify that I attended the deceased from 10-8-43  
to 10-23-43  
that I last saw her alive on Oct. 23, 1943  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race Negro

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan. 3, 1943  
(Month) (Day) (Year)

Immediate cause of death Tuberculous Meningitis

Due to \_\_\_\_\_

Due to \_\_\_\_\_ **14**

8. AGE: Years Months Days If less than one day

20 9 20 hr. \_\_\_\_\_ min.

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

10. Usual occupation child

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

MOTHER FATHER { 12. Name John Washington

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

14. Maiden name Erlie Copeland

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

16. (a) Informant Record Clerk

(b) Address General Hosp. #2

17. (a) Burial (b) Date thereof 10-26-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Westlawn

18. (a) Signature of funeral director W. Jones

(b) Address 440 State Ave

19. (a) 10-26-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 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) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) M.D.

Address General Hosp. #2 Date signed 10-23-43

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

---

---

**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 Eugene English  
Licensed Embalmer No. 465

P. O. Address 440 State Ave. N.E.

**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.**