

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
 (a) County _____
 (b) City or town **St. Louis, Missouri**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis City Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 mo - 12 days**
 (Specify whether _____)
 In this community _____
 years, months or days **0**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **St. Louis**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **5101a Ridge Ave.**
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ **(1)**

3. (a) PRINT FULL NAME **Julius Cope**
3. (b) If veteran, **Nil** **3. (c) Social Security** **Unknown**
 name war _____ No. _____

4. Sex **Male** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **Married**
6. (b) Name of husband or wife **Flossie Cope** **6. (c) Age of husband or wife if alive** **53** years
7. Birth date of deceased **February 2 1891**
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|-----------|-----------|----------------------|
| | 53 | 10 | 16 | hr. _____ min. _____ |

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

10. Usual occupation **R.R. Conductor**

11. Industry or business _____

MOTHER FATHER { **12. Name** **Edward Cope**
13. Birthplace **Unknown Unknown U**
 (City, town, or county) (State or foreign country)
14. Maiden name **Sarah Kaiser**
15. Birthplace **Unknown Unknown U**
 (City, town, or county) (State or foreign country)

16. (a) - Informant **J. B. Cope**
(b) Address **5101a Ridge Ave.**

17. (a) Burial **(b) Date thereof** **12-20-44**
 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Bellflower, Missouri**

18. (a) Signature of funeral director **Albert H. Hoppe**
(b) Address **4700 Washington Blvd.**

19. (a) **DEC 14 1944** **(b) J. F. Brediek**
 (Date registered) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **18th**
 year **1944** hour **5:40 am** M.
21. I hereby certify that I attended the deceased from **11/3/44**
 _____, 19____, to **Dec. 18th**, 19 **44**
 that I last saw him alive on **Dec. 18th**, 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Lobar pneumonia, Bilateral.** **Duration** _____

Due to **52**
Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: **Squamous cell Carcinoma of urethra + perineum.** **PHYSICIAN** _____
Of operations _____ **Underline the cause to which death would be charged statistically.**
Of autopsy **Primary site**

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? _____

(Specify type of place) _____
(Specify means of injury) **0**
23. Signature **Wade** **(M. D. or other)** _____
Address **1515 Lafayette** **12/18/44** **Date signed**

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

OCT 8 1945

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.....

John Agorowski

..... Licensed Embalmer No. *3398*.....

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.