

S. No. 2
M-5-43
5-17-39
I X36671

FILED JUL 22 1947

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 214

1. PLACE OF DEATH:

(a) County Cape Girardeau

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

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week
(Specify whether years, months or days) 9 months

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Howell

(c) City or town West Plains, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME DONIE RAY COPE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex MALE 5. Color or race White

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

6. (b) Name of husband or wife Infant

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

7. Birth date of deceased April 20 1944
(Month) (Day) (Year)

8. AGE: Years 3 Months 2 Days 17 hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Faul COPE

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

14. Maiden name Blair Hedrick

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

16. (a) Informant Mrs Paul Cope

(b) Address Portageville Mo

17. (a) Burial (b) Date thereof July 8 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains Mo

18. (a) Signature of funeral director St. Louis General Co

(b) Address Portageville Mo

19. (a) 7-12-1947 (b) C. C. Summers
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 7
year 1947 hour 1:10 minute P M.

21. I hereby certify that I attended the deceased from July 1 1947, to July 7 1947, that I last saw him alive on July 7 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Intussusception

Duration 3 days

Due to _____

Due to _____

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

Major findings: n/p

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 0

23. Signature Dr. Cochran (M. D. examiner)

Address Cape Girardeau Mo Date signed 7/7/47

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

MOTHER, FATHER

RECEIVED

District Health Officer No. 4

District File Number 747-932

Date Filed 7-19-47

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.