

FILED JAN 25 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

460

State File No.

0164
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BIRTH NO. _____		REG. DIST. NO. <u>53</u>	PRIMARY REG. DIST. NO. <u>3010</u>	Registrar's No. <u>8</u>
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Alexander</u>		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Cape Girardeau Mo.</u>)		c. LENGTH OF STAY (In this place) <u>3 Week</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>8120</u> OR TOWN <u>McClure Ill</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: <u>Cape Osteopathic Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>None</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Virginia</u>		b. (Middle) <u>Lucille</u>	c. (Last) <u>Copeland</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 14 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1915</u> <u>July 21 1916</u>	9. AGE (In years last birthday) <u>34</u> IF UNDER 1 YEAR Months <u>3</u> IF UNDER 24 HRS. Days <u>23</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Miller City Ill.</u>
13a. FATHER'S NAME <u>Jim Mason</u>		13b. MOTHER'S MAIDEN NAME <u>Annie Bradshaw</u>		14. NAME OF HUSBAND OR WIFE <u>Cyril Copeland</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Cyril Copeland</u> ADDRESS <u>McClure Ill</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Failure</u>		INTERVAL BETWEEN ONSET AND DEATH		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES		
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Post Surgical Hepatitis, Pneumonia & Nephritis</u>		
DUE TO (c) <u>Cholecystitis and Cholelithiasis</u>		II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		<u>585X</u>		
19a. DATE OF OPERATION <u>Dec. 30, 1949</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cholecystitis with Cholelithiasis</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <u>Dec. 25, 1949</u> , to <u>Jan. 14, 1950</u> , that I last saw the deceased alive on <u>Jan. 14, 1950</u> , and that death occurred at <u>12:00 p. m.</u> from the causes and on the date stated above.				
23a. SIGNATURE <u>J. H. Howell</u> (Degree or title) <u>D.O.</u>		23b. ADDRESS <u>105 S. Spanish Cape Girardeau, Mo.</u>		23c. DATE SIGNED <u>Jan 17, 1950</u>
24a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 17 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lindsay Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>McClure Ill. Ill.</u>
DATE REC'D BY LOCAL REG. <u>1-17-1950</u>		REGISTRAR'S SIGNATURE <u>L. C. Summers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe H. Howell</u> ADDRESS <u>Cape Gir Mo</u>

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

APR 12 1950

JAN 27 1950

RECEIVED

JAN 23 1950

DISTRICT HEALTH OFFICE No. 4

File No. 150-93

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed W. H. Ester

Licensed Embalmer No. 3568

P. O. Address Espe Lin Mo

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.