

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1701

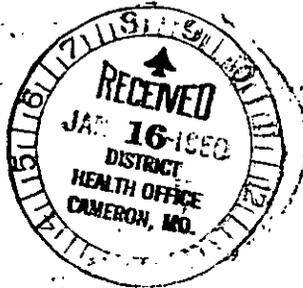
BIRTH NO. _____ REG. DIST. NO. 187 PRIMARY REG. DIST. NO. 2040 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY Livingston		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Carroll	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chillicothe,		c. LENGTH OF STAY (In this place) 4 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Chillicothe Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hale	
		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) Pearl		b. (Middle) Gladys	
		c. (Last) Coppage,	
		4. DATE OF DEATH (Month) (Day) (Year) Jan. 4th 1950	
5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 11th, 1893
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months 1 Days 23	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll County, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wm Joseph Stephens		13b. MOTHER'S MAIDEN NAME Lois Palmer	
14. NAME OF HUSBAND OR WIFE Arthur Coppage			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT'S SIGNATURE OR NAME Mr Arthur Coppage.		ADDRESS Hale, Mo.	
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) Strangulated Umbilical Hernia		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asphyxia, 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) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		5600	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Swing of transverse colon in Strangulated Hernia		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 1-1-1950 to 1-4-1950 , that I last saw the deceased alive on 1-4-50 , 19 50 , and that death occurred at 9:30 P m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Amoswell, M.D.		23b. ADDRESS Chillicothe Mo	
		23c. DATE SIGNED 1-6-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1/6/1950	24c. NAME OF CEMETERY OR CREMATORY Arkadelphia,	24d. LOCATION (City, town, or county) (State) Avalonp Missouri
DATE REC'D BY LOCAL REG. Jan-7-50	REGISTRAR'S SIGNATURE Frances B. Nail	171	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Clifford W. Austin, Tuna Mo

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

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FEB 4 1950



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.

Signed..... *Clifford W Austin*.....

Signed.....
Student Embalmer

Licensed Embalmer No. 3233

P. O. Address Tina, Missouri.

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.