.S. No. 300
v. 10.48

0361

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31435

State File No.

FILED OCT 13 1953

BIRTH NO. REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 4186 Registrar's No. 56

1. PLACE OF DEATH
a. COUNTY FRANKLIN
b. CITY OR TOWN SULLIVAN c. LENGTH OF STAY (In this place) 12HRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTHSIDE HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MO b. COUNTY FRANKLIN
c. CITY OR TOWN SULLIVAN 0361
d. STREET ADDRESS (If rural, give location) 14 HUGHS FORD RD

3. NAME OF DECEASED (Type or Print) a. (First) GLADYS b. (Middle) OLIVIA c. (Last) COPELAND

4. DATE OF DEATH (Month) OCT (Day) 11 (Year) 1953

5. SEX FEMALE **6. COLOR OR RACE** WHITE **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) DIVORCED **8. DATE OF BIRTH** JAN. 20, 1907 **9. AGE** (In years last birthday) 46 IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITRESS **10b. KIND OF BUSINESS OR INDUSTRY** RESTURANT **11. BIRTHPLACE** (City and State or Foreign Country) PAYDOWN MO **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13a. FATHER'S NAME SETH BRAY **13b. MOTHER'S MAIDEN NAME** WALSIE HUTCHINSON **14. NAME OF HUSBAND OR WIFE** —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) — **16. SOCIAL SECURITY NO.** 499-12-3102 **17. INFORMANT'S SIGNATURE OR NAME** GENEVA DACE **ADDRESS** SULLIVAN, MO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis of left Coliac Artery — INTERVAL BETWEEN ONSET AND DEATH 17 Hrs.

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.

19a. DATE OF OPERATION None **19b. MAJOR FINDINGS OF OPERATION** 1/201 **20. AUTOPSY?** YES ☑ NO ☐

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) m. **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* October 10, 1953, *to* Oct 11, 1953, *that I last saw the deceased alive on* Oct 10, 1953 *and that death occurred at* 7 AM m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert M. Crawford (Degree or title) M.D. **23b. ADDRESS** Sullivan Missouri **23c. DATE SIGNED** Oct 11-53

24a. BURIAL, CREMATION, REMOVAL (Specify) **24b. DATE** 10/14/53 **24c. NAME OF CEMETERY OR CREMATORY** Union Hill Cemetery **24d. LOCATION** (City, town, or county) (State) VIENNA, MO.

DATE REC'D BY LOCAL REG. 10/12/53 **REGISTRAR'S SIGNATURE** Thomas A. Humphrey 496 **25. FUNERAL DIRECTOR'S SIGNATURE** H. McCaten **ADDRESS** Sullivan, Mo.

(Licensed Embalmer's Statement on Reverse Side)

OCT 22 1956

NOV 1953

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 J. A. Humphrey

Licensed Embalmer No. 4772

P. O. Address Sullivan, 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.