

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40319
State File No. _____
REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10943

FILED NOV 27 1953

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri, b. COUNTY	
b. CITY OR TOWN St. Louis,		c. CITY OR TOWN St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital		e. STREET ADDRESS (If rural, give location) 12 4828 Delmar Ave.	
3. NAME OF DECEASED (Type or Print) Robert F. Copeland		4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1953.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH Oct. 15, 1890.
9. AGE (in years last birthday) 63.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.	
11. BIRTHPLACE (City and State or Foreign Country) NEW YORK, /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Rachel Copeland		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY No. Nil.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ann Jones, 4828a Delmar Ave.	
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) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 60 days	
*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)	
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	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) m.	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from 11-5-53, to 11-15-53, that I last saw the deceased alive on 11-14-53, and that death occurred at 7:50 AM from the causes and on the date stated above.			
23a. SIGNATURE Clyde E. Kane M.D.		23b. ADDRESS 706 Walton	
23c. DATE SIGNED 11-17-53		24a. BURIAL, CREMATION, REMOVAL Removal	
24b. DATE 11-19-53		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis, County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
DATE REC'D BY LOCAL REG. NOV 17 1953		ADDRESS 4700 Washington.	

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, ~~my~~....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elton R. Remelun*.....

Licensed Embalmer No. *428*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.