

FILED JUL 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

23261

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 154 PRIMARY REG. DIST. NO. 5575 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If not in corporate limits, write RURAL and give township) <u>Grandview</u>	c. LENGTH OF STAY (in this place) <u>9 yrs</u>	c. CITY OR TOWN <u>Grandview</u>	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>6th & Jones</u>		STREET ADDRESS <u>6th & Jones road</u>	

3. NAME OF DECEASED (Type or Print)			DATE OF DEATH		
a. (First) <u>Mary</u>	b. (Middle) <u>Maude</u>	c. (Last) <u>Copeland</u>	(Month) <u>7</u>	(Day) <u>7</u>	(Year) <u>54</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>Feb 12, 1883</u>	9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Mins. _____
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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 (City and State or Foreign Country) <u>Valley Falls Kans</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>George W. Johnson</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Zimmerman</u>		14. NAME OF HUSBAND OR WIFE <u>Ode Copeland</u>	
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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>Ode Copeland</u>		ADDRESS <u>Grandview Mo.</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stroke of Cerebrovascular</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3-3-54-7-7-54</u>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	ANTECEDENT CAUSES Asorbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>High blood pressure.</u> DUE TO (c) <u>Diabetic condition</u>						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>intestinal & Pelvic pathology.</u>						

19a. DATE OF OPERATION <u>7-7-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>None.</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Grandview Jackson Mo.</u>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>7-7-54</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>None</u>		
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22. I hereby certify that I attended the deceased from 3-9-1954, to 7-7-1954, that I last saw the deceased alive on 7-6-1954, and that death occurred at 7:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. E. C. Wyckoff D.O.</u>		(Degree or title)		23b. ADDRESS <u>4036 Troost ave. K.C. Mo.</u>		23c. DATE SIGNED <u>7-7-54</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-10-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Palestine Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Nickman Mills Mo.</u>	
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DATE REC'D BY LOCAL REG. <u>7/8/54</u>	REGISTRAR'S SIGNATURE <u>Stirling E. Goddard</u>	4980	FUNERAL DIRECTOR'S SIGNATURE <u>Ed. R. Grogan</u>	ADDRESS <u>Jones Inc Grandview Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
Signature of Student Embalmer

Signed *Sterling E. Godda*

Licensed Embalmer No. *491*

P. O. Address *Grand*

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.