

Health, Welfare, Public Service

FILED OCT 8 1957

STANDARD CERTIFICATE OF DEATH

348334 STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 165

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>St. Clair Co., Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Washington</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Harris Bend</b> 0930 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>State Hosp. #3</b>		Length of stay in lb <b>0-0-11</b>	d. STREET ADDRESS (If outside, give location) <b>St. Clair Co. Mo</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Rufus Marion Copenhaver</b>			4. DATE OF DEATH Month Day Year <b>Sept. 29 1957</b>			
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5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 7 1889</b>		9. AGE (In years last birthday) <b>68</b> IF UNDER 1 YEAR Months Days Hours Min. <b>? ? ?</b> IF UNDER 24 HRS.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (City and state or country) <b>Ironium Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
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13a. FATHER'S NAME <b>BEN Unknown</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown MARY Hudson</b>		14. NAME OF HUSBAND OR WIFE <b>Diseased</b>			
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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) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>347-28-5619</b>		17. INFORMANT <b>Adm Papers</b>		Address <b>Nevada Mo.</b>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic heart disease</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>SENILE DEMENTIA</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
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21. I attended the deceased from **9-18-57** to **9-29-57** and last saw her alive on **9-28-57**  
Death occurred at **4:15 A** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>[Signature]</b>		22b. ADDRESS <b>NEVADA MO.</b>		22c. DATE SIGNED <b>9-29-57</b>	
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23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>10/2/57</b>		<b>IRONIUM</b>		<b>Ironium Mo</b>	

24. FUNERAL DIRECTOR <b>Schebler Funeral Home</b>		ADDRESS <b>Clinton Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>10-3-1957</b>		26. REGISTRAR'S SIGNATURE <b>Anna E. Ferris</b>	
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *R R Kenney*

Licensed Embalmer No. *3099*  
P. O. Address *Clinton 9m*

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.