

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-012799

STATE FILE NUMBER

FILED APR 21 1959

Registration District No. 99 Primary Registration District No. _____ Registrar's No. 19

10
300
1-57

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY DeKalb	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Grandriver Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Cameron, R.R.#3
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3mi.W.Cameron		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 3mi.W.Cameron

3. NAME OF DECEASED (Type or print) First MARCUS Middle FRANKLIN Last COPE			4. DATE OF DEATH April 2, 1959 Month Day Year	
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5. SEX male	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1867	9. AGE (In years at birthday) 91	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Jennievile, Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Milton Cope	13b. MOTHER'S MAIDEN NAME Harriet Thrush	14. NAME OF HUSBAND OR WIFE Deceased
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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)	16. SOCIAL SECURITY NO. 496-42-2650	17. INFORMANT Address Leon Cope Cameron, Mo.
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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) Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 3da
DUE TO (b) Congestive heart failure.		
DUE TO (c) Generalized Arterio sclerosis.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4500		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"/>	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 12-23-58 to 4-1-59 and last saw her alive on 4-1-59 . Death occurred at 10:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE E. Mooney (Degree or title) D.O.	22b. ADDRESS Cameron, Mo.	22c. DATE SIGNED 4-3-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4- -59	23c. NAME OF CEMETERY OR CREMATORY Graceland	23d. LOCATION (City, town, or county) (State) Cameron, Mo.
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24. FUNERAL DIRECTOR ADDRESS Poland Funeral Home Cameron, Mo.	25. DATE RECD. BY LOCAL REG. 4-16-59	26. REGISTRAR'S SIGNATURE [Signature]
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Laurence J. Thompson*

Licensed Embalmer No. *4725*

P. O. Address *Camden, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.