

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029755

FILED VS SEP 15 1959 200

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 151 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Macon</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Macon Hudson Twp</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeview Rest Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Macon</u> c. CITY OR TOWN <u>Bevier</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>FRANCESCO</u> Middle _____ Last <u>Coppi</u>			4. DATE OF DEATH Month <u>8</u> - Day <u>18</u> - Year <u>59</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pool Maint</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Unkown</u>			13b. MOTHER'S MAIDEN NAME <u>Unkown</u>			14. NAME OF HUSBAND OR WIFE _____	
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. _____		17. INFORMANT <u>Albert Anti</u> Address <u>Shwin</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO (b) <u>acute subdural hemorrhage</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs.</u> <u>22 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>Accidental fall on concrete floor in nursing home.</u>			
20c. TIME OF INJURY Hour <u>9:00</u> a.m. _____ Month, Day, Year <u>8-17-59</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>nursing home</u>		20f. CITY, TOWN, OR LOCATION <u>Macon, Macon, Missouri</u>	
21. I attended the deceased from <u>May 1959</u> to <u>8-17-59</u> and last saw her <u>him</u> alive on <u>8-17-59</u> Death occurred at <u>7:00</u> P. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Ch. R. Nurdson D.O.</u>				22b. ADDRESS <u>Macon, Missouri</u>		22c. DATE SIGNED <u>8-31-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8/20/59</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Bevier Mo</u>	
24. FUNERAL DIRECTOR <u>W. Edwards</u> ADDRESS <u>Shwin</u>			25. DATE RECD. BY LOCAL REG. <u>8/31/59</u>		26. REGISTRAR'S SIGNATURE <u>Keith Nurely</u>		

BY AFFIDAVIT OF Friend, Erma Berti MEDICAL CERTIFICATION DOCUMENT

VS APR 23 1960

FEB 4 1960

JAN 13 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *J. G. Edwards*

Licensed Embalmer No. 1961

P. O. Address *Beaver, W*

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.