

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. 59-100 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <u>Dade</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood</u>		Length of stay in 1b		c. CITY OR TOWN <u>So. Greenfield</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R. R. #</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle _____ Last <u>Copeland</u>				4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-12-1876</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u>	IF UNDER 24 HR Hours _____ Min. _____
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		11. BIRTHPLACE (City and state or country) <u>Ky.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Leveck France</u>			13b. MOTHER'S MAIDEN NAME <u>Bebb Stomper</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT (Name and address) <u>Mrs. Dorothy Rusch Greenfield Mo.</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>Toxicity due to gangrene of left leg</u> DUE TO (b) <u>arteriosclerotic obliteration</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>1 month.</u> <u>3-4 years</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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
21. I attended the deceased from <u>10-22-59</u> to <u>12-23-59</u> and last saw <u>her</u> alive on <u>12-22-59</u> . Death occurred at <u>7:30 Am.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Emeru W. Taylor M.D.</u>				22b. ADDRESS <u>Lockwood, Mo.</u>		22c. DATE SIGNED <u>12-23-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-26-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh</u>		23d. LOCATION (City, town, or county) (State) <u>N.E. of Miller Mo.</u>			
24. FUNERAL DIRECTOR (Name and address) <u>Morris - Seaman Miller Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>12/31/1959</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

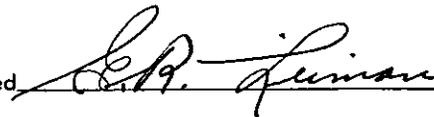
~~or~~ by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 3297

P. O. Address Miller M

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.