

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-028769

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

FILED SEP 5 1961

Registration District No. 93 Primary Registration District No. 4153 Registrar's No. 61-66 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Dade</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lockwood Mo.</u> Length of stay in 1b <u>8 months</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Good Shepard Nursing Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Dade</u> c. CITY OR TOWN <u>Lockwood Mo</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1 mi north</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Arta</u> Middle <u>Copen</u> Last <u>Ellis</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1961</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>April 9 1913</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and state or country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>usa</u>		
13a. FATHER'S NAME <u>Issac Copen</u>			13b. MOTHER'S MAIDEN NAME <u>Francis Copen</u>			14. NAME OF HUSBAND OR WIFE <u>Frank Copen</u>		
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 <u>Mrs Viola VonStrohe Lockwood Mo rt</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>Coronary occlusion</u> DUE TO (b) <u>arteriosclerosis</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>hours</u> <u>years</u>
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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		
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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 checked="" 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>9/4/58</u> to <u>8-28-61</u> and last saw <u>him</u> alive on <u>8/27/61</u> Death occurred at <u>6:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Describe or title) <u>Emeru. Jaylms</u>	22b. ADDRESS <u>Lockwood, Mo</u>	22c. DATE SIGNED <u>8/28/61</u> (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Aug 30 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>IOOF</u>	23d. LOCATION (City, town, or county) <u>Golden City Mo.</u>

24. FUNERAL DIRECTOR ADDRESS <u>Allison Funeral Home Greenfield Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>8/30/1961</u>	26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>
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(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF

DATE AMENDED

INSTEAD OF

SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed W. R. Allison

Licensed Embalmer No. 4404

P. O. Address Greentree

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.