MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 27 STATE FILE NUMBER 61-033583

FILED OCT 2 1961

1. PLACE OF DEATH
a. COUNTY Maries

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Miller

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Boone Twp.
Length of stay in 1b

c. CITY OR TOWN Dixon
Inside Limits Yes ☐ No ☒

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Residence
Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: Rosa Middle: Last: Copeland

4. DATE OF DEATH Month: August Day: 30 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 1-1-1877

9. AGE (last birthday): 84

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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): Miller Co., Mo.

12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Azzarih Pendleton

13b. MOTHER'S MAIDEN NAME: Tenneessee Barnhart

14. NAME OF HUSBAND OR WIFE: William Copeland (dec.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Virgil Copeland Address: Rolla, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Rheumatic heart disease — yes

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Rheumatoid arthritis

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1942, to 8/30/61 and last saw her alive on 8/30/61

Death occurred at 11:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Wm. A. Gould D.O.

22b. ADDRESS Iberia Mo

22c. DATE SIGNED 9/1/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 9-1-1961

23c. NAME OF CEMETERY OR CREMATORY: Wheeler Cemetery

23d. LOCATION (City, town, or county) (State): Iberia (rural), Mo.

24. FUNERAL DIRECTOR: Scrivner-Stevinson ADDRESS: Iberia, Mo.

25. DATE RECD. BY LOCAL REG.: 9-6-1961

26. REGISTRAR'S SIGNATURE: Mozelle Hutchison

(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

VS OCT 3 - 1961

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 T. G. Humphrey

Licensed Embalmer No. 4772

P. O. Address Leslie, 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.