

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-036235

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. A-67 Primary Registration District No. 6258 Registrar's No. 15

FILED NOV 15 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <u>Christian</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>W, Benton Twsp</u>		a. STATE <u>Mo</u>		b. COUNT <u>Christian</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Residence</u>		Length of stay in 1b <u>36</u>		c. CITY OR TOWN <u>Rogersville, Mo Rt 1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>W Benton Twsp</u>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <u>Jessie</u>		Middle <u>Myrtle</u>		Last <u>Copeland</u>		Month <u>II</u> Day <u>3</u> Year <u>61</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/II/1889</u>	
9. AGE (last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </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>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Christian Co, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13a. FATHER'S NAME <u>Jesse Sterling Davis</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Ann Johnson</u>			14. NAME OF HUSBAND OR WIFE <u>Ellis Copeland</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.		17. INFORMANT Address <u>Ellis Copeland, Rogersville, Mo Rt 1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Sepsis + Terminal Pneumonia</u>							<u>1 week</u>
DUE TO (b) <u>Cerebral Hemorrhage</u>							<u>2 months</u>
DUE TO (c) <u>Arteriosclerosis</u>							<u>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 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 <u> </u> a.m. <u> </u> 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>2/12/55</u> to <u>11/3/61</u> and last saw her alive on <u>11/3/61</u>		Death occurred at <u>11/3/61</u> <u>I</u> : <u>P</u> M <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Print or title) <u>Walter R. McCornick D.O.</u>				22b. ADDRESS <u>Ozark Mo</u>		22c. DATE SIGNED <u>11/6/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>II/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sparta</u>		23d. LOCATION (City, town, or county) (State) <u>Christian Co, Mo</u>	
24. FUNERAL DIRECTOR <u>T. Q. Chaffin</u>		ADDRESS <u>Ozark Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 8 / 1961</u>		26. REGISTRAR'S SIGNATURE <u>Nannie Day</u>	

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. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark 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.