

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-019596

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 186

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 28 1962

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>SHELBY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Length of stay in 1b <u>10 DAYS</u>	c. CITY OR TOWN <u>SHELBYNA</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>ST. ELIZABETH HOSP</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RFD</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARCUS ELMER COPENHAVER</u>	4. DATE OF DEATH Month Day Year <u>MAY 20 1962</u>
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5. SEX <u>MALE</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>OCT. 26, 1913</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>SHELBY COUNTY MO</u>	12. CITIZEN OF WHAT COUNTRY <u>US</u>
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13a. FATHER'S NAME <u>JOHN COPENHAVER</u>	13b. MOTHER'S MAIDEN NAME <u>LENA GEHRIG</u>	14. NAME OF HUSBAND OR WIFE <u>MARY COPENHAVER</u>
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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>NO</u>	17. INFORMANT Address <u>MRS MARY COPENHAVER SHELBYNA MO</u>
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18. CAUSE OF DEATH (Enter only one cause per line if DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <u>Acute monocytic leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____		
DUE TO (c) _____		

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.) _____
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20c. TIME OF INJURY Hour s.m. p.m. _____	Month, Day, Year _____
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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 _____
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21. I attended the deceased from 10 May 1962 to 20 May 1962 and last saw her alive on 20 May 1962
Death occurred at 2 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wyneth Hamilton M.D.</u>	22b. ADDRESS <u>Hannibal mo</u>	22c. DATE SIGNED <u>5/22/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>MAY 22, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MAPLEWOOD CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>CLARENCE MO</u>
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24. FUNERAL DIRECTOR ADDRESS <u>GREENING CLARENCE MO</u>	25. DATE RECD. BY LOCAL REG. <u>May 22, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by William M. Herman</u>
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DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
SHOULD READ
BY AFFIDAVIT OF DOCUMENT
MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 Charles V. Keeney

Licensed Embalmer No. 4625

P. O. Address Clarence 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.

Permit issued 5/22/62