

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-017515

DO NOT WRITE
ON THIS STUB

AMENDED

918
 1003
 4267

Registered for District No. 318
 Primary Registration District No. 1003
 Registrar's No. 4267
 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in-hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2832 Semple Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Coplin Last Coplin			4. DATE OF DEATH Month 4 Day 16 Year 63
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Unk.
9. AGE (last birthday) Abt. 77		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Georgia
12. CITIZEN OF WHAT COUNTRY USA		13. NAME OF HUSBAND OR WIFE	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Address A Mrs Rose Morris 2832 Semple Ave.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Bronchopneumonia Hypostasis Chronic Brain Syndrome 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) 491x			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 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 4-1-63 to 4-16-63 and last saw him alive on 4-16-63 Death occurred at 11:50 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>L. H. Wiley M.D.</i>		22b. ADDRESS 2601 N. Whittier	22c. DATE SIGNED 4-17-63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-19-63	23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.,
24. FUNERAL DIRECTOR G. Wade Granberry		ADDRESS 4202 Finney Ave.,	25. DATE RECD. BY LOCAL REG. APR 17 1963
			REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

VS 300
Rev. 4/59

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77

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

USE BLACK INK
 OR
 TYPEWRITER RIBBON

Miscouri

St. Louis

St. Louis

St. Louis

Home G. Phillips

03

16

4

Coplin

William

1917

x

Westo

Miss

Under

Probably Bronchopneumonia

STATEMENT BY LICENSED EMBALMER

Hypostasis

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

Chronic Brain Syndrome

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney Ave.

4-16-03

x

4-16-03

4-16-03

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.

4-17-03