

Dr. E. J. B. 23, 1946
FILED SEP 7 1946

Registration District No. 77

Primary Registration District No. 3016

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
421 Monroe Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 45 years
years, months or days

3. (a) PRINT
FULL NAME

William L. Copas

3. (b) If veteran,
name war _____

3. (c) Social Security
No. None

4. Sex Male 5. Color or
race White

6. (a) Single, widowed, married,
divorced Widower

6. (b) Name of husband or wife

Della Copas

6. (c) Age of husband or wife if
alive _____ years

7. Birth date of deceased July 23 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 1 24 hr. min.

9. Birthplace Moniteau C.nty., Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Retired R.R. Engineer

11. Industry or business _____

12. Name John Copas

13. Birthplace Cooper County, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Birdsong

15. Birthplace Cooper C.nty., Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Evah Williams

(b) Address Jefferson City, Missouri

17. (a) Burial (b) Date thereof Sept-19-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation California, Missouri

18. (a) Signature of funeral director [Signature]

(b) Address Jefferson City, Missouri

19. (a) 9-18-46 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. 421 Monroe Street
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 17
year 46 hour 9 minute 2 M.

21. I hereby certify that I attended the deceased from
9/15/46 to 9/17/46
that I last saw him alive on 9/15/46
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to arterio sclerosis 3 years

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) Means of injury _____

23. Signature: [Signature] (M. D. or other) 9/18/46
Address _____ Date signed _____

RECEIVED
District Health Officer No. 9,
District File Number 9-46-15-9
Date Filed 2-23-46

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.....
....., Registered Apprentice No.....,
working under my personal supervision.

Signed

Licensed Embalmer No. 40611

P. O. Address

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 this body is not embalmed, fact should be so stated above.