

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30204

1. PLACE OF DEATH

County Marion

Registration District No. D. Benton 318

File No. _____

Township _____

Primary Registration District No. 2001

Registered No. 633

City Springfield

No. St. Johns Hospital

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 404 1/2 Walnut St. _____ Ward _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 3 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
28 8 1

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.

10. NAME OF FATHER Fred Carrupt

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

12. MAIDEN NAME OF MOTHER Luisa Carrupt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT (Address) Fred Carrupt
404 1/2 Walnut

15. FILED 8-5-28 Robert M. [unclear] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-4-28

17. _____

I HEREBY CERTIFY That I attended deceased from 8-26-28 to 9-4-28 that I last saw him alive on 9-4-28, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidental poisoning
Bichloride of Mercury
swallowed (duration) yrs. mos. ds. 8

CONTRIBUTORY (SECONDARY) 1/17/17 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? at place of death

19. DID AN OPERATION PRECEDE DEATH? DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? History
9/5-28 (Signed) St. Johnston, M. D.
Springfield Mo. (Address)

*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS and NATURE of INJURY and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

21. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield

DATE OF BURIAL 9-6-28

22. UNDERTAKER John [unclear]

ADDRESS Walnut

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORD

2 1928

1943
1943