25 1929

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

Do not use this space.
28243

1. PLACE OF DEATH
County: Lafayette — Registration District No.: 464 — File No.: 18
Township: — Primary Registration District No.: 4277 — Registered No.: 40
City: Odessa, Mo (No. ..... St. ..... Ward)

2. FULL NAME: W. J. Shupe
(a) Residence. No. ..... St., ... Ward. Circleville, Kans.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Sarah King Shupe

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 1877 - Detroit Kans

7. AGE: Years 77 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer 210 G 210
(b) General nature of industry, business, or establishment in which employed (or employer): 153 B
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY): Va.

PARENTS
10. NAME OF FATHER: Wm. Shupe - first name guess
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY): not known
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY): not known

14. INFORMANT: Oscar Shupe
(Address): Circleville Kan.

15. Sept 10, 1929 — R. A. Croole, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1929, to ....., 19..., that I last saw him alive on Aug 17, 1929, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
(1) Crushing injuries to chest. (2) Fracture ribs (2) Puncture lung
(2) Multiple lacerations of lung, collapse + crushing of left lung, (3) Shock
(duration) ..... yrs. ..... mos. 4 hrs. ..... ds.
CONTRIBUTORY (SECONDARY): Subcutaneous emphysema
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 2
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) N. E. Martin, M. D
8/18, 1929 (Address) Odessa Mo

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

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Circleville, Kan. — DATE OF BURIAL: 8/19, 1929

20. UNDERTAKER: L. C. Kusman — ADDRESS: Odessa, Mo

Bu...

7.35 P.M.

R.D. 3:40 P.M.

at

11:40

1:00

7:20

6:05 P.M.

Crushing injury to chest — fracture ribs — puncture of lung — Multiple lacerations contusions & abrasions of head & face — Shock.

Subcutaneous emphysema

1025
Dr. [illegible] Cell

S-28243
(1929)

8-29

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Lafayette Registration District No. 464 File No. 18
Township Primary Registration District No. 4277 Registered No. 40
City Odessa (No. St. Ward)

2. FULL NAME Mrs. W. J. Sharpe
(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

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

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

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Sept 10, 1929 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Crushing injuries to chest
Automobile accident
on No 40 Highway
(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) 208, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-28243(2)