

NOV 28 1930

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

Do not use this space.

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1. PLACE OF DEATH

County Stoddard Registration District No. 838 File No. \_\_\_\_\_  
Township Essex Primary Registration District No. 6098B Registered No. \_\_\_\_\_  
City Essex RD #1 (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Infant of L. A. Hupp

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 12, 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 12

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) Essex RD. #1, Mo.  
(STATE OR COUNTRY)

PARENTS  
10. NAME OF FATHER L. A. Hupp  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind.  
(STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER Elizabeth Smith  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ill.  
(STATE OR COUNTRY)

14. INFORMANT L. A. Hupp  
(Address) Essex, Mo.

15. FILED 10/24, 1930 F. La Rue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 24<sup>th</sup> 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to Oct. 24<sup>th</sup>, 1930, that I last saw her alive on Oct. 20<sup>th</sup>, 1930, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Septicemia  
155 (duration) \_\_\_\_\_ yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) Abscess of breast jaw bone  
Injury (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? No. DATE OF \_\_\_\_\_  
WAS THERE AN AUTOPSY? No.  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) S. J. Hays, M. D.  
, 19 (Address) Weston 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 Taylor Cemetery DATE OF BURIAL 10/25 1930

20. UNDERTAKER C. O. Biggs ADDRESS \_\_\_\_\_



**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 Stoddard Registration District No. 538 File No. ....  
Township Liberty Primary Registration District No. 6095 B Registered No. ....  
City ..... (No. ....) St. .... Ward)

**2. FULL NAME** Infant Snapp

(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) .....

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) .....

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. FILED 12/10 1920 .....

F. LaRue  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 24 1920

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

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Septicemia  
..... (duration) ..... yrs. .... mos. .... ds.  
CONTRIBUTORY abscess of fractured  
(SECONDARY) jaw bone from forays at  
..... (duration) ..... yrs. .... mos. .... ds.  
birth.

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) ..... M. D.  
, 19 (Address) 161

\*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 .....

20. UNDERTAKER ..... ADDRESS .....

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

CAUSE OF DEATH IS TO BE WRITTEN IN FULL IN THE SPACE PROVIDED THEREFOR. IF THE CAUSE OF DEATH IS UNKNOWN, THE WORD "UNKNOWN" IS TO BE WRITTEN IN THE SPACE PROVIDED THEREFOR.

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MADE IN  
U.S.A.