

X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41993
Registrar's No. 368

FILED JAN 7 1948
Registration District No. 1944

Primary Registration District No. 3012

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Excelsior Springs Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: McClary Hospital & Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Indiana (b) County DeKalb
(c) City or town Auburn Ind
(If outside city or town limits, write "RURAL")
(d) Street No. Rural R.R. 3
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____ 2

3. (a) PRINT FULL NAME DONALD ARTHUR CUPP

3. (b) If veteran, name war no 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 9
year '43 hour 1 minute 20 P.M.
21. I hereby certify that I attended the deceased from 12
8 1943 to 12-9 1943
that I last saw him alive on 12-9 1943
and that death occurred on the date and hour stated above.

Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Jesse Cupp 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 28-1907
(Month) (Day) (Year)

Immediate cause of death Asphyxia Duration 24 hrs

8. AGE: Years 36 Months 8 Days 11 If less than one day _____ hr. _____ min.

Due to Ordinary (Preliminary) 3 lab
hepatitis

9. Birthplace Auburn Ind
(City, town, or county) (State or foreign country)

Due to _____

10. Usual occupation Farming

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business _____

PHYSICIAN

12. Name Arthur Cupp

Major findings: Of operations _____

13. Birthplace Auburn Ind
(City, town, or county) (State or foreign country)

Of autopsy _____

14. Maiden name Bertha Elizabeth

Underline the cause to which death should be charged statistically.

15. Birthplace Auburn Ind
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Jesse Cupp

(b) Address Auburn R.R. 3

17. (a) Auburn Ind (b) Date thereof 12/10/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Auburn Ind

18. (a) Signature of funeral director Robert Stone

(b) Address Excelsior Springs Mo.

19. (a) 12-10-48 Mrs. E. Redman
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury _____

23. Signature Paul V. Wooley (M. D. or other) _____
Address Excelsior Springs Mo. Date signed 12-10-43

11 10 6

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-6-44

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

J. J. Moles

Licensed Embalmer No.

3296

P. O. Address

Exp. Springs, Mo.

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Clay
(b) City or town Estelcion Springs
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mc Clearys Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 da (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Donald A. Cupps

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Mar. 28 - 1910
(Month) (Day) (Year)

8. AGE: Years 36 Months 8 Days 5 (If less than one day, _____ min.)

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia Duration 24 hr.

Due to Oedema - Pulmonary Sub.

Due to Nephritis Chronic

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 131 R Physician

Of operations _____ Underline the cause to which death should be charged statistically.
Of autopsy _____

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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-41993