

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 6136
 Registrar's No. 892

FILED MAR 6 1944
 Registration District No. 119

Primary Registration District No. 1002

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 5 days
(Specify whether
 In this community 39 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Jackson
(If outside city or town limits, write "RURAL")
 (d) Street No. 1312 Troost Ave
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Dannell N. Hupp
 3. (b) If veteran name war _____ 3. (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month February day 23
 year 1944 hour 10 minute 40 A.M.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb - 9 - 1893
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from February 18, 1944, to February 23, 1944;
 that I last saw him alive on February 23, 1944;
 and that death occurred on the date and hour stated above.
 Immediate cause of death Cerebral Hemorrhage Duration _____

8. AGE: Years 51 Months 0 Days 4 If less than one day _____ hr. _____ min.

Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations 830
 Of autopsy None

9. Birthplace Kansas
(City, town, or county) (State or foreign country)
 10. Usual occupation Shoemaker
 11. Industry or business _____
 12. Name D. Hupp
 13. Birthplace Hot Springs 9
(City, town, or county) (State or foreign country)
 14. Maiden name Hot Springs
 15. Birthplace Hot Springs 9
(City, town, or county) (State or foreign country)

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. S. D. Hupp
 (b) Address 1312 Troost Ave
 17. (a) Removal (b) Date thereof 2-23-44
(Reason, transportation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Ant Hope N.C.
 18. (a) Signature of funeral director Libert Jones
 (b) Address Removal City, Removal
 19. (a) 2-23-44 (b) T. E. Baum
(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 0
 23. Signature A. E. Uecker (M. D. or other) M. D.
 Address Med. Dir. Gen'l Hosp. Date signed 2-23-44

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..... *Phil C. Gibson*.....

Licensed Embalmer No. *3135*.....

P. O. Address *Kenosha City, Kenosha*.....

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.