No. 2
—5-43
5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3343

Registration District No. 209 FILED FEB 15 1946 Primary Registration District No. 3043 Registrar's No. 35

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Elizabeth Hospital
(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. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion 64

(c) City or town Hannibal
(If outside city or town limits, write "RURAL")

(d) Street No. RR#1 Hannibal
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Ronald E. Rupp

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Male

5. Color or race White

6. (a) Single, ~~widowed, married, divorced~~ 0

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Aug (Month) 6 (Day) 1939 (Year)

8. AGE: Years 6 Months 1 Days 9 If less than one day ..... hr. ..... min.

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

10. Usual occupation Student

11. Industry or business .....

FATHER
12. Name Herbert Rupp
13. Birthplace Marion Co (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Genieve Till
15. Birthplace Quincy (City, town, or county) Ill (State or foreign country)

16. (a) Informant Mrs Genieve Rupp
(b) Address Marion Co RR#1

17. (a) G Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Grant View Burial Park

18. (a) Signature of funeral director James O'Donnell
(b) Address Hannibal Mo.

19. (a) 1-16-46 (Date received local registrar) (b) Dr. E. M. Lucke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 15 year 1945 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from Sept 14, 1945, to Sept 15, 1946 that I last saw him alive on Sept 15, 1946 and that death occurred on the date and hour stated above.

Immediate cause of death wound Provisional mass of Brain by fragment of Shell

Due to Explosion

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 64

(b) Date of occurrence Sept 14-46

(c) Where did injury occur? Marion Co (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on farm in home (Specify type of place)

While at work? ..... (e) Means of injury Explosion

23. Signature [signature] (M. D. ~~or other~~)

Address Hannibal Mo Date signed Jan 16-46

18 (Licensed Embalmer's Statement on Reverse Side)

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

100612

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.....

Licensed Embalmer No.....

P. O. Address.....

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.