

**FILED MAY 9 1946** STANDARD CERTIFICATE OF DEATH

Registration District No. 316

Primary Registration District No. 6075

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington RURAL St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Hospital No. 4 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 mos. 20 das.  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois 94  
(c) City or town Doe Run 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CARRIE L. HUPP

3. (b) If veteran, name war No 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Charles C. Hupp 6. (c) Age of husband or wife if alive Age Unk. years

7. Birth date of deceased June 16, 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	10	9	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Ruppert

13. Birthplace Germany 4  
(City, town, or county) (State or foreign country)

14. Maiden name Caroline Arbogast

15. Birthplace Alsace-Lorraine France 5  
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) Burial (b) Date thereof 4-28-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Doe Run Cem., Doe Run, Mo.

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Missouri

19. (a) 5-3-46 (b) Cethild Rudloff  
(Date received from registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 25  
year 1946 hour 3 minute 10 P. M.

21. I hereby certify that I attended the deceased from February 5, 1946 19\_\_\_\_ to April 25, 1946 19\_\_\_\_;  
that I last saw him or alive on April 25, 1946 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 1 day

Due to \_\_\_\_\_

Due to cerebral arteriosclerosis 2 yrs  
psychosis with

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy No autopsy.

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) \_\_\_\_\_

(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)  
(c) Means of injury \_\_\_\_\_

23. Signature D. H. Cozean (M. D. or other) \_\_\_\_\_

Address Farmington Date signed 5/3/46

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

13143

RECEIVED

District Health Officer No. 4

District File Number 546-2120

Date Filed 5-8-46

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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. 408 f

P. O. Address Farmington 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.**