

FILED JUL 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 19023
Registrar's No. 6

BIRTH NO. _____ REG. DIST. NO. 87 PRIMARY REG. DIST. NO. 5324

1. PLACE OF DEATH a. COUNTY CRAWFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN 36	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOURBON, RURAL, Boone		c. LENGTH OF STAY (in this place) 3 Das.	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stanton		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Bernard	c. (Last) Sappington	4. DATE OF DEATH (Month) (Day) (Year)	June 13 1949
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH Sept. 27, 1931	9. AGE (In years last birthday) 17	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Hours 16
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Sullivan, Missouri 0	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME J. B. SAPPINGTON	13b. MOTHER'S MAIDEN NAME BERNICE GALLINGER	14. NAME OF HUSBAND OR WIFE Single
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498-32-3645	17. INFORMANT'S SIGNATURE OR NAME Letha Sappington	ADDRESS Stanton, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Struck by lightning		INTERVAL BETWEEN ONSET AND DEATH 9:35 AM 28
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE Act of God	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Bourbon, Boone Twn. Crawford Mo.
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 13 1949m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Struck by lightning 28
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22. I hereby certify that I attended the deceased from 3:05 P.M., 1949, to 3:05 P.M., 1949, that I last saw the deceased alive on 6/15/49, and that death occurred at 3:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) Coroner 3	23b. ADDRESS Cuba, Missouri	23c. DATE SIGNED 6/14/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Rural	24b. DATE 6/15/49	24c. NAME OF CEMETERY OR CREMATORY Stanton Cem.	24d. LOCATION (City, town, or county) (State) Stanton Mo
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DATE RECD BY LOCAL REG 6/15/49	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE [Signature]	ADDRESS Sullivan, Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

28
0
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JUL 8
1949

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.....

T. A. HUMPHREY

Student Embalmer No. 316

working under my personal supervision.

Student *J. A. Humphrey*

Student Embalmer

Signed

Edgar W. Laffoon

Licensed Embalmer No. 3394

P. O. Address Sullivan, Missouri

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.