

FILED MAY 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13774**
Registrar's No. **131**

BIRTH NO. 22273-50 REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043

0644

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

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ralls</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Hannibal</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>NW London 0870</u>	
c. LENGTH OF STAY (in this place) <u>2 days</u>		d. STREET ADDRESS (If rural, give location) <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LARRY</u>	b. (Middle) <u>EUGENE</u>	c. (Last) <u>EPPELSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 23 1950</u>
-------------------------------------	-------------------------	---------------------------	---------------------------	---

5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>April 21-1950</u>	9. AGE (In years last birthday) <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 1 HRS. Hours <u>2</u>	IF UNDER 1 MIN. Min.
-----------------------	----------------------------------	--	--	---	---------------------------------------	--------------------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Hannibal, Missouri, U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	-----------------------------------	--	---

13a. FATHER'S NAME <u>BOBBY EUGENE EPPELSON</u>	13b. MOTHER'S MAIDEN NAME <u>DAISY RUTH EPPELSON</u>	14. NAME OF HUSBAND OR WIFE
--	---	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <u>MO</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Daisy EppeLson</u>	ADDRESS
---	--------------------------------------	---	---------

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.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intracranial Hemorrhage (Cerebral)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>Birth</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last: 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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 Am., from the causes and on the date stated above.

23a. SIGNATURE <u>Ronald B. Jordan, M.D.</u>	(Degree or title)	23b. ADDRESS <u>Hannibal, Mo.</u>	23c. DATE SIGNED <u>4/24/50</u>
---	-------------------	--------------------------------------	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>April 24-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>	24d. LOCATION (City, town, or county) (State) <u>Frankford Mo</u>
---	-----------------------------------	---	--

DATE REC'D BY LOCAL REG. <u>4-25-50</u>	REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Fields</u>	ADDRESS <u>Frankford, Mo.</u>
--	---	---	----------------------------------

RECEIVED APR 27 1950
MARION CO. HEALTH DEPT.
DATE FILED MAY 2 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed: *Lore Fields McGowan*

Licensed Embalmer No. *4073*

P. O. Address *Frankford Pa*

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.