

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37527

BIRTH NO. _____ REG. DIST. NO. 159 PRIMARY REG. DIST. NO. 4249 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY Jefferson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri COUNTY Iron TOWN Arcadia		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Hillsbonough		c. LENGTH OF STAY (in this place) 5 months	c. CITY (If outside corporate limits, write RURAL and give township) TOWN Arcadia		
d. FULL NAME OF HOSPITAL OR INSTITUTION Cedar Grove Nursing Home			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) a. (First) ULYSSES b. (Middle) JEFFERSON c. (Last) PROPST			4. DATE OF DEATH (Month) (Day) (Year) Nov. 22 1950		
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar. 22 1876		9. AGE (In years last birthday) 74	10. UNDER 1 YEAR Days 8	11. UNDER 1 MIN. Hours 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cape County Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME John Propst		13b. MOTHER'S MAIDEN NAME Nancy Propst		14. NAME OF HUSBAND OR WIFE Zoe Propst	
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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. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS John Kuhn, Arcadia Mo.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach		1. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				1 year?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						151X	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from June, 1950, to Nov. 22, 1950, that I last saw the deceased alive on Nov. 20, 1950, and that death occurred at 4:00A M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas A. Donnell M.D.		23b. ADDRESS Desoto, Mo.		23c. DATE SIGNED 11-25-50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 11-25-50	24c. NAME OF CEMETERY OR CREMATORY Masonic Cem.	24d. LOCATION (City, town, or county) (State) Ironton Missouri		
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DATE REC'D BY LOCAL REG. 11-25-50	REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS White Funeral Home, Ironton Mo. [Signature]		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

05-00
4

JEFFERSON COUNTY HEALTH DEPT.
HILLSBORO, MISSOURI
DATE RECEIVED 12-8-50

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 *Paul J. White*

Licensed Embalmer No. *3012*

P. O. Address *Clinton, 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.