

FILED AUG 11 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24215

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6069 Registrar's No. 249

1. PLACE OF DEATH a. COUNTY ST FRANCOIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MO b. COUNTY ST FRANCOIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL SPON		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL SPON 0140	
d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) 1/2 miles E. OF Bismarck	

3. NAME OF DECEASED (Type or Print) a. (First) TRAUOGOTT	b. (Middle) C.	c. (Last) ZAPF	4. DATE OF DEATH (Month) (Day) (Year) July 27 1951
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5. SEX MALE	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 3 Nov. 1868	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 3 Day 24	IF UNDER 2 HRS. Hours 4 Min.
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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	11. BIRTHPLACE (State or foreign country) Germany Briefer	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME ADAM ZAPF	13b. MOTHER'S MAIDEN NAME UNKNOWN JORDON	14. NAME OF HUSBAND OR WIFE Deceased
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No file	17. INFORMANT'S SIGNATURE OR NAME Henry Zapf	ADDRESS Bismarck, 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis 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 21 11	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) (Min.)	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 **July 26, 1951**, to **July 26, 1951**, that I last saw the deceased alive on **July 26, 1951**, and that death occurred at **12:45A. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James W. Buffman	23b. ADDRESS Bismarck, MO.	23c. DATE SIGNED 7-31-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7-29-51	24c. NAME OF CEMETERY OR CREMATORY MASONIC	24d. LOCATION (City, town, or county) (State) BISMARCK, MO.
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DATE REC'D BY LOCAL REG. JULY 31, 1951	REGISTRAR'S SIGNATURE Esther Rudolph	25. FUNERAL DIRECTOR'S SIGNATURE Shipman-Lewis	ADDRESS Bismarck, MO.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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File No. _____
DISTRICT HEALTH OFFICE No. 4

AUG 6 1951

RECEIVED

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 _____

JOHN N. SHIPMAN

Student Embalmer No. 415

working under my personal supervision.

Student John N. Shipman
Student Embalmer

Signed Buried In

Licensed Embalmer No. 4287

P. O. Address Flat River, 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.